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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

COMPLETED

ORIGINAL

Jail Inmates' Mental Health Care Neglected; State And Federal Attention Needed

Many persons in the Nation's 4,000 jails have mental health problems, but most jails do not identify all inmates needing help or provide for their proper care. In 1973 a national advisory commission recommended that States improve jail services, and some States have made limited progress by adopting professional standards. But little has been done to improve mental health care by ensuring that jail personnel are adequately trained or that community health agencies provide services for inmates either in jail or through community-based alternatives.

This report discusses ways in which programs conducted by several Federal agencies could be more effective in helping States improve jail mental health services. It also recommends ways the Bureau of Prisons could provide better mental health care to inmates of Federal jails.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-199001

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses problems and progress in providing for mental health care for jail inmates. It was prepared to identify ways in which the Federal Government could promote needed improvements, not only in locally operated facilities, but also in its own.

We are sending copies of this report to the Attorney General; the Secretary of Health and Human Services; and the Director, Office of Management and Budget.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

JAIL INMATES' MENTAL HEALTH CARE NEGLECTED; STATE AND FEDERAL ATTENTION NEEDED

DIGEST

The Nation has some 4,000 jails--detention facilities that hold inmates from a few hours to 1 year. Studies indicate that from 20 to 60 percent of the approximately 142,000 persons in jails on any given day have mental health problems. But most jails do not identify all inmates needing help or provide for their proper care.

In 1971, The Law Enforcement Assistance Administration established the National Advisory Commission on Criminal Justice Standards and Goals to formulate national criminal justice standards and goals at the State and local levels. The Commission found a general lack of funding and program innovation at the local level and it concluded that few local communities, especially in sparsely settled areas, have sufficient resources to resolve jails' problems and provide appropriate health and other services. In 1973, the Commission recommended the States assume responsibility for operating and controlling local jails by 1982. If States did not assume control, it recommended a number of alternative actions, including

--adoption of professional, statewide standards for jails, and State inspections to ensure compliance;

--State supervision of and assistance for training of jail personnel; and

--State-supervised comprehensive planning to ensure that all appropriate community services agencies were used to provide services for inmates in jails or through community-based alternatives.

Tear Sheet. Upon removal, the report cover date should be noted hereon.

GAO found that States have made only limited progress in implementing the Commission's recommendations. States generally have not assumed responsibility for operating and controlling local jails, and, although some have initiated efforts to implement the Commission's alternative recommendations, their efforts have been restricted in scope and are, for the most part, incomplete. Some States are adopting mandatory professional standards for jail mental health services. (See pp. 11 to 14.) However:

--States have done little to overcome widespread inadequacies in the training of local jail personnel. (See pp. 14 to 16.)

--Criminal justice and health systems continue to operate separately, with little interaction or cooperation.

None of the States GAO visited had comprehensively assessed inmates' mental health care needs and community agencies' capacity to meet them or linked criminal justice and health systems to provide services for inmates in jails and through community-based alternatives. (See pp. 17 to 22.)

THE FEDERAL GOVERNMENT CAN DO MORE TO PROMOTE STATE ACTION

Although improving mental health care in locally operated jails is not primarily a Federal responsibility, financial and technical assistance programs administered by the Department of Justice's U.S. Marshals Service, Law Enforcement Assistance Administration, and National Institute of Corrections, and by institutes of the Department of Health and Human Services' Alcohol, Drug Abuse, and Mental Health Administration could aid the States in bringing mental health care services for inmates up to acceptable standards.

The programs are not a panacea, but they could provide aid for implementing statewide standards and for ensuring appropriate use of community service agencies. (See ch. 3.)

THE FEDERAL GOVERNMENT SHOULD IMPROVE SERVICES IN ITS OWN FACILITIES

The Department of Justice's Bureau of Prisons operates three Metropolitan Correctional Centers, the equivalent of jails. The two Centers GAO visited did not always adequately screen incoming inmates or provide for adequate treatment for inmates having behavioral disorders. Also, treatment deviated from professional standards in that neither had a program for alcoholism, and one lacked a program for drug addiction. Although the deficiencies were attributable, in part, to funding constraints and personnel shortages, GAO believes correction of management shortfalls would improve services and facilitate better use of resources. The Bureau should:

--Give greater priority to providing clerical support for professional mental health personnel to increase the time they have available for professional duties.

--Ensure that appropriate ongoing psychological reinforcement training is provided to physician's assistants engaged in identifying mental health problems.

--Require that a psychological file be established for each inmate identified as mentally ill and that the psychological diagnoses, treatment, and results be recorded. (See ch. 4.)

RECOMMENDATIONS

Some Federal programs have already made useful contributions to jail mental health care. However, various steps could be taken to enhance their overall impact. Among other things, GAO recommends that the Department of

Justice and the Department of Health and Human Services further coordinate their efforts pertaining to mental health care for jail inmates to better assure that Federal efforts are directed at common goals and are mutually supportive.

GAO recommends that the Attorney General:

--Require the Administrator of the Law Enforcement Assistance Administration to aid the States in achieving an ongoing capability for helping their jails by expanding the training opportunities for State personnel who train local jail staffs.

--Require the Director of the National Institute of Corrections to ensure that its Jail Center provides training for State jail inspectors in mental health care services and establishes a program of demonstration and training in the implementation of professional standards for mental health care services in at least some, and eventually all, Jail Area Resource Centers.

GAO also recommends that the Secretary of the Department of Health and Human Services:

--Direct the National Institute of Mental Health and the National Institute on Alcohol Abuse and Alcoholism to revise guidelines for comprehensive statewide mental health and alcoholism plans to make it clear that State agencies should assess the needs of jail inmates in the planning process.

--Direct the National Institute of Mental Health to furnish guidelines to community mental health centers and State agencies responsible for mental health that specifically describe the ways in which centers could assist jails.

--Strengthen National Institute on Drug Abuse procedures for reviewing the comprehensive plans of State agencies responsible for drug planning to ensure that the drug treatment needs of jail inmates are considered.

AGENCY COMMENTS

The Departments of Justice and Health and Human Services commented on a draft of this report by letters dated September 24, 1980, and September 22, 1980, respectively. (See app. I and II.)

The Department of Justice stated that, in general, the report presents a fairly thorough critique of mental health care conditions in State and local jails and provides good insight into the problems of providing mental health care to jail inmates. The Department stated that GAO's recommendation that LEAA provide for training of State jail inspectors and other appropriate State personnel was realistic and deserving of LEAA's support, but pointed out that the LEAA program was being phased out of existence.

The report's recommendation was made at a time when the future of LEAA was uncertain. In fact, final appropriation decisions have not yet been made. If LEAA is phased out of existence, alternative sources of funding for all of the LEAA initiatives discussed in this report will have to be found if they are to continue.

The Department of Health and Human Services stated that it would review present and future activities most carefully to assure that emphasis on care for jail inmates is ongoing and persistent and that strategies are jointly developed with other Federal and State agencies. The Department agreed with all of the report's recommendations except one concerning the National Institute on Drug Abuse's limitation on treatment slots for persons from the criminal justice system.

After assuring itself that limitations were not being placed on referrals from the criminal justice system, GAO deleted this recommendation from its report.

A detailed analysis of agency comments is included on pages 56 to 59 and 67 to 69.

APPENDIX

I September 24, 1980, letter from the Assistant Attorney General for Administration, Department of Justice 70

II September 22, 1980, letter from the Inspector General (Designate), Department of Health and Human Services 75

III List of organizations visited or contacted 82

ABBREVIATIONS

ACA	American Correctional Association
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AMA	American Medical Association
BOP	Bureau of Prisons
DOJ	Department of Justice
HHS	Department of Health and Human Services
LEAA	Law Enforcement Assistance Administration
MCC	Metropolitan Correctional Center
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIC	National Institute of Corrections
NIDA	National Institute on Drug Abuse
NIMH	National Institute of Mental Health
SIP	Standards Implementation Program
TASC	Treatment Alternatives to Street Crime

CHAPTER 1

INTRODUCTION

Federal, State, and local governments are spending about $3 billion annually to house approximately 500,000 inmates daily in about 4,500 institutions. These institutions range in size from large prisons, housing thousands of inmates, to small jails housing a few. One of the most pressing problems in these correctional institutions is providing inmates with adequate health care.

Proper health care has become a major prisoners' rights issue in recent years, and correctional officials, courts, and legislatures have concluded, to varying degrees, that inmates must have access to it. This report, our third on health care in correctional institutions, addresses mental health care in jails. It discusses problems as well as progress, and it identifies ways in which the Federal Government can promote needed improvements--not only in locally operated facilities, but also in its own. 1/

For the purpose of this report, the term "mental health care" covers a broad spectrum of inmate problems, namely psychosis, neurosis, behavioral disorders, and alcohol and drug abuse and addiction.

STUDIES HAVE INDICATED THAT A SIGNIFICANT NUMBER OF JAIL INMATES HAVE MENTAL HEALTH PROBLEMS

Various studies indicate a significant number of the approximately 142,000 inmates housed in jails daily have mental health problems. A 1979 study done for the National Coalition for Jail Reform estimated that 20 to 35 percent of the jail population was mentally ill, while a study done for the National Institute of Corrections estimated that up to 60 percent of the persons confined

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1/Previous reports were: (1) "A Federal Strategy is Needed to Help Improve Medical and Dental Care in Prisons and Jails", (GGD-78-96), Dec. 22, 1978), and (2) "Prison Mental Health Care can be Improved by Better Management and More Effective Federal Aid", (GGD-80-11), Nov. 23, 1979).

are mentally ill, disturbed, or disordered. Studies of various jails have also shown that many jail inmates have mental health problems. For example:

- --A study of the Denver County Jail showed that 22 percent of 545 inmates were diagnosed as psychotic, and 23 percent had a history of long term or multiple hospitalization for mental illness.

- --Research conducted in March and April of 1979 at the Milwaukee House of Corrections showed 17 percent of the total jail population had been diagnosed by the facility's consulting psychiatrist as mentally ill.

Jails are the intake point for the entire criminal justice system, and the United States has over 4,000--ranging in size from a 4-cell area in a rural sheriff's office to 1,000-bed facilities in major metropolitan areas. About three-fourths of local jails are relatively small--holding 20 or fewer persons. Jails house up to 5.5 million people each year and detain diverse categories of persons for varying amounts of time. This includes persons awaiting arraignment who may be held for a few hours, persons awaiting trial or sentencing, and sentenced offenders serving up to 1 year. The length of time inmates spend in jail is usually brief.

Because of such factors as the size of jails and the time that inmates spend in them, not all elements of inmate mental health services can or should be provided by jails themselves. It would not be economically feasible for many jails, small ones in particular, to maintain a full range of mental health care services. Recognizing this, recent jail health care standards have emphasized the use of community service agencies.

ROLE OF THE FEDERAL GOVERNMENT

The Federal Government provides mental health care to inmates in Federal correctional institutions and furnishes States and localities with financial, technical, and other forms of assistance that can be used in providing for mental health services for jail inmates.

At the Federal level, the Bureau of Prisons operates three Metropolitan Correctional Centers, which are the Federal equivalent of jails. These facilities, which are located in Chicago, New York City, and San Diego, housed a total of about 1,293 inmates as of June 1980.

State and local facilities can receive aid from the Department of Justice through the Law Enforcement Assistance Administration (LEAA) and the National Institute of Corrections (NIC). Also, the institutes of the Department of Health and Human Services' Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) can involve jail inmates in their mental health care programs. A detailed discussion of the Federal aid to States and localities for jail mental health care is included in chapter 3.

OBJECTIVES, SCOPE, AND METHODOLOGY

To determine the adequacy of mental health care for local jail inmates throughout the country, we made literature searches; examined court decisions; reviewed reports and studies published by professional groups and Federal, State, and local agencies; and interviewed officials from various national organizations, such as the American Medical Association, National Coalition for Jail Reform, and National Sheriffs' Association. We also reviewed records and studies and interviewed corrections officials and officials responsible for mental health care in nine States. To observe the adequacy and actual delivery of health care services to inmates, we visited 12 jails in 4 States and selected local mental health care agencies. A detailed listing of the organizations, agencies, States, and local jails visited is included in appendix III.

We reviewed policies and procedures and interviewed State officials responsible for planning for criminal justice programs and for mental health, alcohol and drug abuse, and addiction programs in nine States to (1) assess their role in helping localities provide mental health care in jails, (2) determine the type of programs available and being used by the jails, and (3) determine what the State role should be in assisting the jails in meeting inmate needs.

We interviewed officials and reviewed policies and procedures at the Department of Health and Human Services' National Institutes for Mental Health, Alcohol, and Drug

Abuse; and Department of Justice's LEAA and NIC to (1) assess their role in helping States to improve mental health care for local jail inmates, (2) determine what Federal programs are available and being used by the States, and (3) determine what the Federal role should be in assisting the States to improve mental health care for inmates of local jails.

The primary reason for our visits to the State and local jails was to identify ways in which the Federal Government could improve its health care assistance to them. The States in our review were selected on the basis of their geographic location and were not considered by us to be better or worse than those we did not visit. Because the focus of this report is not on evaluating the specific health care problems of individual States, they generally have not been identified unless they seemed to be making headway in solving certain problems. This was done so that other States might be able to contact them to obtain additional information.

To determine the adequacy of mental health care given Federal inmates, we reviewed the Bureau of Prisons and U.S. Marshals Service policies and procedures for providing mental health services. To observe the actual delivery of health care, we visited two Federal Metropolitan Correctional Centers and interviewed the correctional and mental health staffs, observed activities, and inspected facilities. We visited some local jails where Federal prisoners were housed and interviewed U.S. Marshals who were responsible for housing of Federal prisoners.

CHAPTER 2

STATES NEED TO MAKE A GREATER EFFORT TO IMPROVE MENTAL HEALTH CONDITIONS IN LOCAL JAILS

Our review showed that although some improvements have been made in recent years, extensive shortfalls still exist in the mental health services provided for jail inmates. Jails were not adequately screening inmates to identify their mental health care needs or providing them with adequate care.

In order to formulate national criminal justice standards and goals at the State and local levels, LEAA, in 1971, established the National Advisory Commission on Criminal Justice Standards and Goals. The Commission found a general lack of funding and program innovation at the local level, and it concluded that few local communities, especially in sparsely settled areas, could be expected to have sufficient resources to resolve jails' problems and provide appropriate health and other services. In its 1973 report on corrections, the Commission recommended that the States assume the responsibility for operating and controlling local jails by 1982. In the absence of State control, the Commission recommended a number of alternative State actions, including

--adoption of professional, statewide standards for jails and State inspections to ensure compliance;

--State supervision of and assistance for training of jail personnel; and

--State-supervised comprehensive planning to ensure that all appropriate community service agencies were used to provide services for inmates in jails and community-based treatment as an alternative.

Overall, States have made only limited progress in implementing the Commission's recommendations. They generally have not acted to assume responsibility for operating and controlling local jails. Some have begun efforts to implement the Commission's alternative recommendations, but the efforts have been restricted in scope and are largely incomplete. For example, some States have established mandatory professional, statewide standards for services, but little has been done to enlist the cooperation of community service agencies for improving the services provided to inmates or for expanding alternatives to jailing.

MENTAL HEALTH SERVICES FOR JAIL INMATES ARE STILL DEFICIENT

Until the early 1970s, little data had been compiled regarding the status of health care delivery systems in the Nation's jails. The results of a major study at that time indicated, among other things, that extensive deficiencies existed in the mental health services available to inmates. Subsequent studies, court cases, and other information we obtained in our review indicated that the deficiencies in such services continue to exist.

In 1971, the American Bar Association voiced concern to the American Medical Association (AMA) about the defective quality of medical services in correctional institutions, particularly in jails. AMA held discussions with the National Sheriffs' Association and the American Correctional Association (ACA)[1] and sent a survey questionnaire to 2,900 sheriffs. Over 40 percent responded, painting a dismal picture of health care accessibility in their jails. Regarding mental health, the survey indicated that only 14 percent of the responding jails had facilities for the mentally ill, only 20 percent had any special facilities for handling alcoholics, and only 10 percent had facilities for drug abusers. Subsequent studies indicated a similar pattern. In a 1976 LEAA-financed study of drug treatment, one-third of 118 jails surveyed had no systematic screening to identify drug users. And, 1977 studies by the Department of Justice and the AMA showed that only one-third of the jails surveyed had alcoholism treatment programs, and few jails were equipped to deal with the mentally ill.

Prompted in part by court interventions in inmate care, the ACA published jail standards in 1977 that incorporated standards for health services which had been developed by AMA. The standards stated that jails should identify and make provision for treating inmates' problems. More specifically, jails were supposed to have written standard procedures governing mental health care services, and provide for the following:

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[1] ACA was founded in 1870. Its primary purposes are to exert a positive influence on the shaping of National Correctional policy and to promote the professional development of persons working within all aspects of corrections.

--Initial screening of all inmates upon admission, primarily to identify those having problems needing immediate attention--such as the potentially suicidal.

--Within 14 days after admission, a more indepth screening (health appraisal) to ensure inmates' needs are known.

--Referral of the suspected mentally ill to appropriate health care facilities in lieu of detention.

--Provision for 24-hour emergency care.

--Medically supervised detoxification of alcohol and drug abusers.

--A special program for inmates requiring close medical supervision, including the known or suspected mentally ill, and the alcoholic and drug dependent.

--Counseling and program services for inmates having alcohol and drug problems.

--Separate management of inmates having special problems, including the mentally ill and alcohol and narcotic addicts.

Additionally, the standards provided that jails have a program of release preparation to give inmates information on community agencies that could assist them after release.

Although the standards made clear the specific services that were needed, our review showed that deficiencies still exist. State officials in the nine States we visited during our review informed us that mental health care services in their jails were generally deficient. Reports and studies illustrated the situation:

--An official in one of the States told us in 1979 that deficiencies indicated in a 1976 State survey of jails in 77 counties still prevailed. According to the survey, only about 18 percent of inmates who jail administrators felt needed mental health care were receiving it, and administrators estimated that about 44 percent of the inmates needed some form of drug and alcohol counseling.

--A 1977-1978 survey of 38 of the 88 county jails in another State showed that a number of jails would not meet selected ACA standards described above. Of the 38 jails surveyed:

  - -only 5 jails had written policies and procedures for medical services,
  - -only 26 jails had a designated licensed physician, and
  - -only 15 jails performed intake medical examinations on inmates.

We found further indications of deficiencies in our visits to 12 jails in 4 States. Included were 2 large-size jails with an inmate capacity of 266 to 770, and 10 medium-size jails having an inmate capacity of 33 to 240. Although we were advised by State correctional or State planning agency authorities that 11 of the 12 jails were among the better ones in the respective States, the services in many of them were deficient. The extent of the shortfalls is illustrated in the following summary, stated in terms of the number of jails which did not meet the specific ACA standard involved:

--Ten of the jails did not have written procedures governing mental health care.

--Five did not screen all inmates to identify mental health care needs.

--Four did not provide 24-hour emergency services for the mentally ill.

--Seven did not have counseling and program services for drug or alcohol abusers.

--Nine had no special medical program for inmates requiring close medical supervision due to mental illness or alcohol problems, and eight had no such program for drug problems.

--Eleven did not have a release preparation program to provide information on community agencies that could assist inmates needing aftercare.

In general, services were much more complete in the two large jails--each screened all inmates, had counseling and program services for substance abusers, and had special medical programs for the known or suspected mentally ill. But we also noted that efforts to upgrade services in these two jails had stemmed from court orders.

Inadequate mental health care has frequently been an issue in a number of conditions-of-confinement cases filed against jails in Federal and State courts. Among other things, inmates have cited inadequate screening and treatment for problems and the need for additional medical staff. They have claimed that the conditions-of-confinement, including inadequate mental health care, fall well below the standards required by statute or by the Constitution. In many cases, the courts have found the conditions present significant health and safety risks to inmates and staff alike and have responded in a number of ways--ranging from ordering minor improvements to appointing a special monitor to oversee the jail operations.

A case involving a jail in Allegheny County (PA) illustrates the point. In that case, inmates with a wide spectrum of mental problems, clothed in hospital gowns or left naked, were bound to canvas cots with a hole cut in the middle. A tub was placed underneath the hole to collect the body wastes. Prisoners also were required to sleep in canvas cots, many of which were discolored by vomit, feces, and urine. Testimony indicated that inmates lacked access to mental health care. Finding violations of the Eighth Amendment and constitutional due process guarantees, the U.S. District Court for the Western District of Pennsylvania forbade the further use of restraint cots, limited the use of restraints, and ordered all nurses to get psychiatric training.

Contending that the relief granted by the District Court failed to, among other things, raise the level of psychiatric care at the jail to the constitutionally required minimum, the inmates appealed to the Circuit Court. The Circuit Court articulated standards of what level of psychiatric care would meet the constitutional minimum and remanded the case back to the District Court to determine the adequacy of care. The Court said that systematic deficiencies in staffing, available facilities, or procedures may effectively deny inmates access to needed diagnosis and treatment. When it results in deliberate indifference to a prisoner's serious physical or mental illness, the Court concluded that failure to provide adequate treatment violates the Eighth Amendment's ban against cruel and unusual punishment and due process guarantees.

In another case, the U.S. District Court for the Northern District of Illinois ordered extensive improvements in mental health care and required periodic reports to the court on the implementation of such orders. In Lucas County, Ohio, a Federal judge appointed a special master to oversee court ordered improvements in the jail's conditions.

Prisoner class action suits raising Eighth Amendment, due process, and other constitutional challenges have proliferated in recent years. But, while court intervention can improve conditions and is necessary in some instances, for several reasons it is not the most desirable solution for every case. Successful conditions-of-confinement cases usually result in some form of court order directed to and binding upon only the parties to the lawsuit. Penal systems and institutions not parties to the litigation generally are not bound by court orders. This is a major drawback to relying upon litigation to identify and remedy substandard conditions on a broad scale.

Litigation is by its nature reactive--that is, it generally deals with existing conditions that are sufficiently severe to warrant court action. Condition-of-confinement cases ordinarily are not filed to prevent the development of substandard conditions. Further, litigation is sometimes ineffective because the substandard conditions involved, though serious, may be insufficiently severe to violate law or the Constitution in the view of the court hearing the case.

Additionally, litigation can be expensive and slow--it is not uncommon for the final disposition to take several years. Until the case is resolved, unacceptable conditions may continue to exist.

STATES HAVE MADE ONLY LIMITED PROGRESS

The States have made only limited progress in implementing the National Advisory Commission's 1973 recommendations. States generally have not acted on the recommendation to assume responsibility for operating and controlling local jails. Although some have initiated efforts to implement the Commission's alternative recommendations, the efforts have been restricted in scope and, for the most part, are incomplete.

According to a 1979 study prepared for LEAA, States have overwhelmingly rejected the idea of State control of local jails. As of June 1978, jails were operated by State correctional agencies in only six States (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont), and only one of these States had assumed responsibility subsequent to the Commission's recommendation in the matter. Officials of various States and correctional professional groups told us that substantially expanded State control of jails is not a realistic possibility because of strong political opposition on the part of local governments.

Some States have begun implementing alternative actions the Commission had recommended, but much more remains to be done. Some are adopting mandatory professional standards for jail mental health services. However, the efforts necessary to enable jails to achieve compliance have on the whole been lacking. The evidence is that little has been done to provide training to jail personnel, enlist the cooperation and support of community service agencies for improving the services available to inmates, or expand community-based treatment alternatives to jailing.

Professional standards are being adopted by some States but are not yet being enforced

One of the major recommendations of the National Advisory Commission was that States legislate professional State standards for jail facilities and program operations and establish State jail inspections to ensure compliance. Important progress has recently been made. In 1977, ACA promulgated uniform professional standards for jails, and these incorporated AMA-developed standards for health, including mental health, services. And, as of late 1979, seven States had adopted the basic health standards as State standards, and four others were taking action to do so.

Standards describe what is proper and adequate for a given purpose. They are essential for making sound determinations of needs and for verifying that the services provided to inmates are the services that should be provided. They thereby furnish a basis for establishing realistic priorities for improving services and for rationally allocating resources. Periodic inspections, with effective procedures for enforcement, are a means of stimulating improvements and are needed to assure jailers implement and continue to maintain standards. Also, a statewide group of inspectors can be a source of knowledge to identify jail deficiencies and problems.

In its 1973 report, the National Advisory Commission noted professional standards existed and were enforced in virtually every public institutional sector except the correctional sector. As examples, it cited school systems and medical facilities. It referred to a survey made in 1971 which showed that 20 States had no jail standards and that some had standards for facilities but not for services. Moreover, standards for services that did exist varied considerably, and many were vague and thus difficult to enforce. An American Bar Association official told us that because of its own study of existing State standards for health services and court cases highlighting variations, vagueness, and lack of professional input, they concluded that standards for these services were of little use and not legally enforceable.

On the basis of discussions of the situation with the American Bar Association and correctional professional groups and information obtained from a survey of jails, AMA in 1975 undertook to develop professional standards for jail health, including mental health, services that would reflect organized medicine's viewpoint of adequate services. The standards it developed were extensively tested in 30 pilot jails--urban and rural; small, medium, and large--in 6 States representing each of the Nation's major geographical regions. They were found to be realistic, on the basis of an independent evaluation that included surveys of sheriffs and an analysis of the extent to which the pilot jails had been able to implement them, and they were approved by the National Sheriffs' Association.

When the ACA published what it termed the first comprehensive measureable jail operating standards for nationwide use in 1977, it incorporated the jail health standards developed by AMA. As of late 1979, seven States had adopted the basic AMA standards for jail health services (California, Illinois, Ohio, Oklahoma, South Carolina, Texas, and Washington). We were advised that four others were in the process of doing so.

Of the nine States we visited, five had mandatory standards for jails that included standards for mental health services, and each could inspect for compliance and initiate enforcement. Three of these--Illinois, Ohio, and South Carolina--had incorporated AMA standards for these services.

--Illinois established the jail standards in 1977 and was inspecting jails at least annually for compliance.

--Ohio established its jail standards in 1978. They were to be implemented in phases over 3 years. A State official advised that additional inspectors would be requested to enable annual inspections. He told us they would be requested in part because some States having jail standards had recently been sued for nonenforcement.

--South Carolina issued new standards for jails in 1979. They were to become effective in phases from July 1979 to July 1981. We were advised inspections would begin in 1980 and be performed at least annually.

The remaining two of the five States were inspecting jails, but their standards for mental health services were described by State officials as minimal and vague or too general and difficult to enforce, and they were in part nonmandatory. One of them, however, had initiated action to adopt AMA standards.

As regards the other four States visited:

--One did not have standards for jails.

- --Two had mandatory standards for jails and were inspecting for compliance, but the standards did not address mental health services.

- --One had nonmandatory standards for jail mental health services.

While standards and inspections are important, they do not in themselves enable jails to achieve compliance. For example, Illinois had adopted AMA jail health standards in 1977 and was inspecting jails annually, but an official told us only 5 of the 98 jails were in full compliance. In Ohio, an official estimated it would, optimistically, take 3 to 5 years to implement the State's 1978 jail health care standards. For jails to achieve compliance with standards, jail staffs must be adequately trained, and jails must obtain assistance from appropriate community agencies--factors that are discussed in the paragraphs that follow.

States need to make sure that jail personnel are adequately trained

The National Advisory Commission, recognizing the importance of adequately trained jail personnel and extensive deficiencies in their training, recommended that the States set qualifications for jail staff members and assume responsibility for providing a program of preservice and in-service training and staff development for all jail personnel. States need to take much more effective action if widespread shortfalls in the training of local jail personnel are to be overcome.

ACA standards provide that all jail staff should be trained to recognize symptoms of mental illness and drug and alcohol abuse. Further, jail managers should be trained not only as to the mental health care services that should be provided inmates but also on how they could go about implementing them. However, deficiencies in the training of jail personnel in general have been widespread and persistent. In 1973, the Commission reported that jail employees "almost invariably are untrained," and, in 1979, an Advisory Board of the National Institute of Corrections, in hearings regarding jails' needs, found training "a near unanimous area of focus."

The general shortfalls include mental health training. For example, 4 of the 12 jails we visited had not trained all staff to recognize symptoms of mental illness. In a 1979 national seminar on improving mental health services in jails, psychological and jail personnel stated that training required for guards was almost nonexistent. A task force, which studied mental health care in jails in 1 of the States visited, found that only 7 of the 77 counties surveyed had provided correctional officers the available training in mental health care matters.

Personnel of some jails have been given training in mental health matters by local health agencies. At one of the county jails we visited (Grand Traverse County, Michigan) for example, community mental health staff trained jail staff in assessing and handling problems or potential crises situations. Personnel of some jails have also received federally sponsored training under an LEAA-assisted AMA standards implementation demonstration project and NIC programs. (See pp. 23 and 27.)

Although these efforts are beneficial, they reach only a small number of the Nation's over 44,000 jail personnel. And, because of the high turnover rate among jail staff, there is a constant need for training new personnel.

Some of the States we visited have acted to provide training in mental health matters through their basic jailer training courses or special programs. For instance, New York's basic jailer training included a section on mental health. West Virginia planned to provide nine 2-day jail operations training courses which would include a 3-hour session concerning mentally ill and suicidal inmates.

However, such training is insufficient to enable jails to meet professional standards on a statewide basis. It is too limited in scope, and jailer participation is not always mandatory.

Information we obtained from States that have adopted, or are acting to adopt, AMA jail health standards illustrates the need for expanded training to help jail managers implement them. South Carolina, one of the States that adopted the standards, had provided training to jail personnel in the handling of mentally ill and substance abusing inmates as part of a 40-hour basic jailer training course. But since adopting the AMA standards, it has had to supplement and expand its efforts. Memorandums, manuals, and other literature have been sent to jail managers instructing them in how the standards can be implemented. In addition, State inspectors and consultants from a technical firm are available to assist jailers. Even with this added effort, an official told us she was uncertain as to how long it would take jails to meet the standards.

An official in another State, which had adopted the standards in 1977, told us jailers needed better training in mental health matters. In this State, few jails had fully complied with the standards involved. In fiscal years 1976 and 1977, the State had conducted a jailer training program which in part addressed health services, but because of budget limitations it discontinued the program.

In Michigan, which was in the process of adopting the AMA standards, the Department of Corrections developed a 3-day training program for correctional officers on "Abnormal Behavior in the Correctional Setting," to equip them to recognize and handle inmates affected by such problems as suicidal behavior, mental illness, and drug and alcohol abuse. However, the administrator told us jail managers must have training to be able to implement the AMA standards. He planned some training in implementing the standards through a training film provided by AMA and was currently working with three counties to determine what was involved, but he said that the effort was meager. He said the department did not have the funds or resources to do much more.

We also noted that voluntary training was having little widespread impact. In one State, a task force which studied mental health care in county jails recommended training be mandatory when it found that only 7 of the 77 counties surveyed had provided correctional officers the available training in mental health care matters. The State jail standards, awaiting legislative approval, will provide for mandatory training. Another State offered a voluntary 80-hour jailer training which included a segment on mental health, but a State official told us that few counties would pay for jailers to attend. He believed there was a dire need for mandatory training.

State planning to facilitate use of community resources has been limited

State standards and inspection form only part of the process by which mental health care for inmates can be improved. Because it is usually not economically feasible for jails to develop a full range of in-house services, both ACA and AMA stressed that, to meet professional standards, jails must have the cooperation of community health agencies. Their involvement is essential to enable jails to meet inmate needs, and to help reduce the burden on jails by providing, when appropriate, community-based treatment. The criminal justice and health systems, however, have historically operated separately, with little interaction or cooperation.

The National Advisory Commission recognized that the historically separate operations of jails and community service agencies could hinder jails from making significant progress on their own. Accordingly, it recommended that States, through a systematic, comprehensive planning process, ensure the various elements of the criminal justice and mental health systems--the jail, courts, and law enforcement agencies, and the mental health care agencies--work together to develop and maintain adequate services. More specifically, it recommended that States act to

--comprehensively assess offenders needs and the community health agencies' capacity to meet these needs, and

--systematically link the various elements of the criminal justice and health systems to provide services for inmates confined in jails and through community-based alternatives to confinement.

The Commission believed this comprehensive approach would not only lead to the most efficient use of resources, but it would also pinpoint areas where local resources were insufficient so that new approaches, such as regional jails, could be developed.

None of the States visited had adequately followed this comprehensive approach. We found that jails had generally not obtained the assistance needed from community agencies to provide adequate care for inmates and that community-based treatment alternatives were limited or almost totally lacking. Only two States had taken any significant action to facilitate community treatment for the mentally ill offender. And, although States have done more to facilitate community assistance for offenders with drug and alcohol problems, they were far from achieving the statewide service system envisioned by the Commission.

State action to facilitate community assistance for mentally ill offenders was limited

Only two of the nine States visited--Michigan and Wisconsin--had taken action to facilitate community agency assistance for mentally ill persons confined in jail, and none of the States had taken adequate action to develop community-based alternative services for the mentally ill. Rather than following the comprehensive approach recommended by the Commission, the States generally had left the matter up to the local communities.

Michigan--Michigan had made the most progress of the States visited in establishing a statewide system to provide mental health care to offenders confined in jails. In 1976, Michigan established an interdepartmental committee, comprised of staff from the Departments of Mental Health, Corrections, and Management and Budget, and representatives from the Michigan Sheriffs' Association and others to examine the problems in providing adequate mental health services to county jail inmates. The committee assessed the need for mental health services in the jails and the adequacy of community services; evaluated State policies and procedures related to service delivery; and made recommendations for legislative, policy, and procedural change and development.

The committee found that services for mentally ill jail inmates throughout the State were generally limited and inadequate. The committee recognized the need for the State to facilitate improvements and its ability to do so on a statewide basis through its legal, regulatory, advisory and funding authority over local jails and mental health agencies.

According to the committee's report, those county jails which had mental health programs for inmates had such programs due to the efforts of some "energetic person" within either the jail or the community, and not because of a systematic effort on the part of State agencies to establish them. At the time of its study, no single State agency had assumed responsibility for the delivery of mental health services to jail inmates. The Department of Corrections, for example, told the committee that because of other priorities it had not emphasized mental health treatment and services for jail inmates. Further, the report points out that the statutory jail rules encouraged, but did not require, jails to provide such services. The Department of Mental Health had also had little involvement in assuring that services were provided to mentally ill inmates, resolving local problems, or providing guidance to local mental health agencies.

Since 1976, when the first effort to assess services and identify problems began, Michigan has been taking various actions to eventually establish a statewide system to deliver adequate mental health services to jail inmates. Action to adopt AMA jail health standards was initiated, and a training program for jail officers was developed. Also, the Michigan Mental Health Code was amended in January 1979 to clarify that persons confined in jails were eligible for community mental health services.

At the time of our visit, the Department of Mental Health was beginning a project to collect some basic data--such as the number of inmates needing care, the specific types of services needed, and capacity of existing local resources to meet these needs--at three pilot jails. Officials said this basic information was needed to make future decisions and establish policies for statewide implementation of local service delivery systems. Some of the further matters to be addressed include overall cost, need for additional staff, and alternative service delivery systems for various size jails.

Much remains to be done, however, and one official estimated it may be several years before significant improvements will be evident on a statewide basis.

Wisconsin--At the time of our visit, Wisconsin was in the process of comprehensively addressing the need to care for their mentally ill jail inmates and the problems hindering adequate care. Wisconsin's fiscal year 1979-80

State Mental Health Plan described current problems similar to those found in Michigan and the other States visited:

> "At present, forensic services are highly fragmented due to the need for statute revision, coordination of * * * efforts, lack of resources, and inadequate training * * * county jails report a lack of resources and training for dealing with mentally ill inmates, and policy/procedures for dealing with community supervision of forensic patients are either confusing or nonexistent."

A State official pointed out that jails often lacked adequate physical facilities to provide care, State agencies had not coordinated their efforts, mental health personnel were reluctant or afraid to work in jails, data on the number of inmates needing care and the adequacy of services currently provided was lacking, and services varied considerably from jail to jail. He said the main overall problem had been the lack of a systematic, integrated statewide approach.

Wisconsin's goal is to develop a comprehensive statewide plan for a highly integrated service delivery system which emphasizes community involvement. The action steps described in their fiscal year 1979-80 State Mental Health Plan coincide with those recommended by the National Advisory Commission. Wisconsin's plan was to:

--Identify problems with the current system.

--Solicit input (needs assessment) of mental health, correctional, and legal personnel.

--Survey present programs for mental health/jail services/jailer training.

--Develop various training capabilities to educate judges, law enforcement personnel, and jailers.

Other States--The other seven States visited had not taken any significant action to ensure care for offenders throughout the State. Neither State corrections agencies nor the agencies responsible for mental health planning knew how many offenders needed care or the type of care needed. State mental health agencies generally did not know whether local health agencies were adequately assisting jails or whether they had the capacity to do so.

The States had done little to facilitate cooperation between jails and local mental health agencies. For instance, State mental health agencies had not provided policies, guidance, or directions to local mental health agencies to clarify their roles and responsibilities for jail inmates. Moreover, in some States, the corrections and mental health agencies themselves could not agree on their respective roles and responsibilities. For instance, State corrections personnel in one State did not inspect jail mental health care because they said it was the mental health agency's responsibility.

In sum, these States had left the matter up to each local community rather than taking the comprehensive approach recommended by the Commission, and they were far from achieving a statewide system of care of mentally ill offenders. Many jails had not obtained community assistance to treat inmates in jail, and community-based treatment as an alternative to jailing was almost totally lacking.

State actions to facilitate community assistance for substance abusing offenders were limited

Our review work on services for substance abusing offenders centered primarily on those five States visited that had mandatory standards for jails that included standards for mental health services (Ohio, South Carolina, Michigan, Illinois, and Wisconsin) because we believed such States would be more likely to have taken action. We found that although these States had done more to facilitate community agency assistance for offenders with drug and alcohol problems than for the mentally ill, their efforts were generally limited.

Three of the five States had decriminalized public intoxication and were working toward providing treatment rather than jailing for public inebriates. Most of the

States had also provided some financial, training, or technical assistance for interested communities to support substance abuse programs for inmates in jail and community-based alternatives to jailing.

While these State efforts are beneficial, much more needs to be done. Community treatment for inmates in jail was limited. Community-based treatment programs were also limited and usually the result of a Federal grant.

At the time of our visit, none of the five States knew the number of offenders needing care or the type of care needed. State agencies had only limited information on the assistance local agencies provided offenders, and, as a result, they generally did not know whether existing resources could meet offenders' needs. Without this fundamental data and cooperative comprehensive planning by the State Criminal Justice and mental health systems, existing resources can hardly be allocated and used in the most efficient manner; and realistic alternatives, goals, and priorities cannot be developed to address unmet service needs.

CONCLUSIONS

Recognizing that jails usually lack the resources to achieve significant improvements by themselves, the National Advisory Commission on Criminal Justice Standards and Goals had recommended in 1973 that States take a sequence of actions to assure that adequate services are made available. However, the States in general have been slow to respond, and deficiencies continue to exist in the mental health services provided for jail inmates.

Implementing the actions necessary to improve the situation, including the establishment of professional, statewide standards for jail mental health services and effective inspection programs to ensure compliance; supervision of and assistance for training of jail personnel; and State-supervised comprehensive planning to assure that community service agencies are involved in providing services for inmates in jails is primarily the responsibility of the States. But Federal agencies have played a part in assisting improvement efforts that have been taken, and we believe they could take various steps to more effectively provide such assistance in the future. This matter is discussed in detail in the following chapter.

CHAPTER 3

THE FEDERAL GOVERNMENT CAN DO MORE TO PROMOTE STATE ACTION

Financial and technical assistance programs administered by the Department of Justice's U.S. Marshals Service, LEAA and National Institute of Corrections, and by institutes of the Department of Health and Human Services' Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) could aid the States in bringing mental health care services for inmates up to acceptable standards. The programs are not a panacea, but they could aid in implementing statewide standards for services, and in ensuring appropriate use of community service agencies in meeting inmates' needs.

Some of the programs have already made useful contributions; however, Federal agencies could take various steps to enhance the overall impact of their programs. Department of Justice agencies, for example, have given only limited attention to assisting the States in implementing standards for jail mental health care services. ADAMHA institutes have done little to help assure that community service agencies address inmates' needs. In addition, efforts of Department of Justice agencies could be better coordinated with related activities of ADAMHA.

DEPARTMENT OF JUSTICE COULD DO MORE TO PROMOTE ALTERNATIVES TO JAILING AND IMPLEMENTATION OF STANDARDS

The U.S. Marshals Service, LEAA, and NIC could take several actions that would enhance the Federal contribution to State and local efforts to improve jail mental health care services.

--The U.S. Marshals Service's personnel have direct contact with about 800 local jails that house Federal prisoners. If these individuals were trained, they could assist these jails in implementing standards for mental health and substance abuse services.

--LEAA assistance has done much to bring about the development and implementation of uniform professional standards for jails and to demonstrate ways to refer substance abusers to community treatment as an alternative to incarceration. However, LEAA's emphasis has been largely aimed at implementing the standards on a jail-by-jail basis, and it has given insufficient attention to promoting State action to implement standards statewide. In addition, LEAA has been unable to include the mentally ill in its program to demonstrate ways of diverting offenders to community treatment, because it has experienced difficulty in obtaining the needed cooperation of ADAMHA's National Institute of Mental Health (NIMH).

--The NIC Jail Center furnishes training and technical aid to jails and as part of the effort operates a network of regional exemplary jails designed as area resource centers. While one of the Center's primary objectives is to promote professional jail standards, its programs regarding mental health were limited, and training efforts were directed mainly at personnel of individual jails rather than at personnel of State agencies.

The Marshals Service is in a unique position to assist local jails in improving mental health care

The U.S. Marshals Service contracts with local jails for the housing of Federal prisoners. At the time of our review, it had contracts with about 800 of the Nation's approximately 4,000 jails, and it had routine, recurring contacts with these facilities. The Service also has a staff of enforcement specialists (inspectors) who are required to inspect the contract jails and attempt to assist their administrators in upgrading their facilities and services. These factors put the Service in a unique position to help jails improve mental health services, but some changes are needed before it can provide extensive assistance.

The Marshals Service planned to train its enforcement specialists to do an in-depth health care analysis of jails using standards developed by AMA. Because it lacked expertise regarding the standards, the Service negotiated with AMA for assistance in implementing the training. In April 1979, AMA submitted a concept paper for a $326,015 project to develop a comprehensive training program for the Service's field staff as well as for technical assistance to the Service at the national, regional, and State levels. The training program included 84 hours of understanding and applying AMA standards in evaluating services in local jails. However, this was not implemented because the Department of Justice determined that the Service did not have the legal authority to contract with other agencies for this purpose.

Thereafter, AMA submitted a proposal to NIC, relating primarily to the Marshals Service, for the development of a training package for Federal and State jail inspectors at a cost of $37,143. The program was to:

--Give enforcement specialists knowledge of how to interpret and apply AMA health standards and an increased ability to provide individual jails with information regarding how to correct various deficiencies identified in their existing health care systems.

--Be a vehicle by which the training could be extended selectively to State jail inspectors from areas where qualified jails were in short supply.

Subsequent discussions by AMA officials with NIC staff revealed that the budget would need to be reduced to $30,000 because of insufficient funds. Eventually AMA declined to participate because of its involvement in two other major programs.

Training the Service's 92 specialists in applying standards would provide more competent technical assistance to about 800 contracted jails. Offering training to State jail inspectors in areas where there is a shortage of local jails for housing Federal prisoners, as the Service had planned to do, would extend the assistance even further.

In a previous report, we discussed the problems of finding local jails in which to house Federal prisoners. 1/ Although that report pertained to the Bureau of Prisons, the Marshals Service has also had to contract with local jails that were some distance away from the area in which they were needed. This practice has increased the time, manpower, and cost of transporting prisoners to and from the courts.

A Marshals Service official told us the Service has had difficulty interesting local sheriffs in housing Federal prisoners primarily because the fees for housing them are paid not to the sheriffs but to county governments. He agreed that training assistance for local jailers and State inspectors might be a way of increasing sheriffs' interest. If such assistance resulted in making more jails available in areas where they were needed, its cost could potentially be offset by a reduction in the costs involved in transporting prisoners to more distant jails.

LEAA could do more to expand alternatives to jailing and to train State personnel in the implementation of statewide standards

LEAA assists States and localities in improving their law enforcement and criminal justice systems, including corrections. A high percentage of LEAA funds are made available to the States in the form of block grants, which are in turn sub-granted by the States to units of general local government. Its remaining funds are reserved for award at the discretion of the Administrator of LEAA for, among other things, demonstration, research, and technical assistance programs.

LEAA has used discretionary funds to significantly assist the development and implementation of uniform professional standards for jails. However, LEAA training assistance has focused on implementing standards on a jail-by-jail basis and has put insufficient emphasis on training State personnel to implement them statewide. In addition, an LEAA program demonstrating ways to divert

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1/"Housing Federal Prisoners in Non-Federal Facilities is Becoming More Difficult," (GGD-77-92, Feb. 23, 1978).

substance abusers to community treatment as an alternative to incarceration has not been expanded to include the mentally ill. LEAA has had difficulty obtaining necessary cooperation and support from NIMH.

LEAA assistance has played a significant role in the development of standards

In recent years, LEAA discretionary funds have assisted the development of uniform professional standards for jail health services, including mental health care services. Lack of such standards had hindered action to improve jail services, and their development has provided the States a better basis for establishing and enforcing statewide professional standards.

In fiscal year 1975, LEAA awarded a grant to ACA for development of a detailed set of standards which could be used for accreditation of correctional systems. At the same time, and to complement the ACA efforts, LEAA awarded a grant to the AMA for a project to develop standards and a national accreditation process specifically for jail health services. The project was one element of a joint effort to improve medical care and health services in all types of correctional institutions. The undertaking represented the first general action by organized medicine to address the health care of inmates.

The efforts yielded substantially better guidance as to the services jails should provide. In 1977, ACA published the first comprehensive measureable jail operating standards for nationwide use, and they incorporated the basic jail health standards developed and tested by AMA.

LEAA also provided financial assistance to AMA for development of further, more detailed standards for jail psychiatric and substance abuse that AMA published in 1979.

LEAA program to promote implementation of AMA standards makes inadequate provision for facilitating the implementation of standards statewide

As a followup to the assistance it provided for development of standards for correctional institutions, LEAA, in fiscal year 1978, initiated a Standards Implementation Program (SIP) which provides discretionary funds to support the adoption of standards for health care and alcohol and drug treatment programs in prisons and jails. Under the program's medical health care component, LEAA in April 1979 awarded AMA a $1.2 million grant for the period May 1979 to April 1980 for a project to encourage the widespread adoption of jail health care standards by means of a jail accreditation process. We were advised that an additional $950,000 has been requested to carry the program through May 1981. It was undertaken to demonstrate its effectiveness in a nucleus of selected States, with a view of later expanding it to more States.

The project involves a joint effort by AMA and the State medical society in each participating State. AMA develops a "project coordinator" in each medical society and, through a subgrant, provides about $40,000 for the coordinator's salary and administrative expenses. The coordinator in each State works with 10 to 12 participating jails, and is responsible for

--assisting and training the local units of government in the meaning and use of the AMA standards, and

--assisting by consultation and site visits in the establishment of a mechanism for incorporating the standards into the jails.

AMA assists the medical societies in planning and administering their project, trains the coordinators, and assists in establishment of advisory groups of physicians. A total of 212 jails were involved, under projects conducted by medical societies in 22 States.

As we see it, the project is a useful means of improving jail mental health care services, but its potential for facilitating widespread improvements is limited. The project is primarily aimed at assisting the implementation of AMA standards in local jails that have an interest in adopting them. Accordingly, it includes provision for training personnel of local jails. However, it does not include training of State jail inspectors and/or State personnel responsible for training local jail staff. Thus, it does not provide a mechanism whereby State agencies could incorporate the expertise developed through the project and apply it in their own efforts to implement standards in jails statewide. The focus on training personnel of individual jails largely limits the project's impact to jails that want to become accredited--and only 18 percent of the 1,957 jails eligible for the project in the States involved had expressed an interest in participating.

AMA's project director agreed with our view that it would be appropriate and worthwhile to include provision for training State personnel. At the time of our review, LEAA was considering a proposal for a project to train cadres of State mental health and jail personnel in three States specifically in the implementation of AMA standards for jail psychiatric services. It would be aimed at training trainers to provide the State itself with an ongoing capability to extend the efforts to all jails in the State.

In addition to initiating assistance for the above AMA project, LEAA, in 1979, initiated an effort to promote the implementation of ACA jail standards, which included the basic AMA health standards, by agreeing to fund development by NIC of additional jails in an NIC network of jail area resource centers. However, we found that action is needed to ensure that the centers provide assistance specifically regarding standards for mental health care services and for efforts on a statewide basis. The matter is discussed in more detail on pages 34 to 38.

LEAA program to expand alternatives to jailing could be made more comprehensive

Using discretionary funds and with NIDA assistance, LEAA has conducted a Treatment Alternative to Street Crime (TASC) demonstration program to reduce drug/alcohol-related crime and criminal recidivism by identifying substance abusing offenders, and referring them to community-based treatment programs. The program has been favorably received. However, LEAA has been unable to expand it to include the mentally ill, because LEAA has had difficulty securing needed involvement by NIMH.

Since 1972, LEAA has funded about 60 TASC demonstration projects at the local level. The projects provide a linkage between the criminal justice system and the treatment community and thereby allow the criminal justice system to utilize, where appropriate, alternatives to jailing of substance abusers, either before trial or as a sentence alternative. Their primary functions include:

(1) screening of the arrestee population to identify drug/alcohol abusing offenders, and

(2) diagnosis of a substance abuse problem and referral to community-based treatment.

LEAA is responsible for monitoring and funding projects, and NIDA monitors and funds the treatment component. LEAA has spent over $30 million in developing, testing, demonstrating, and evaluating the TASC concept.

An independent evaluation study completed in June 1978 concluded that

--projects had had a positive impact in criminal justice systems;

--the functions of screening, diagnosis and referral, and client monitoring were effective;

--the TASC process outcome was beneficial when outcomes of TASC clients were compared with non-TASC clients; and

--TASC was cost effective.

Moreover, 90 percent of the TASC projects were funded by States or localities upon expiration of Federal funding.

Under provisions of the Justice System Improvement Act of 1979 (Public Law 96-157, 93 Stat. 1167), LEAA has designated TASC as a national priority program; that is, one entitled to additional Federal aid because it has been shown to be effective or innovative and to have a likely beneficial effect on criminal justice. And, to obtain maximum impact and reach a larger number of jail inmates, LEAA is emphasizing statewide TASC projects in lieu of local ones. With statewide programs, all jurisdictions, including rural areas, needing TASC services will be covered. At the time of our review, three States were operating statewide programs, and more were planned.

Although the TASC concept has been received favorably, LEAA has not been successful in efforts to expand the program to include provision for referring mentally ill individuals to community treatment. Our work indicated it is a potential vehicle for doing so. The TASC screening units may identify an individual with mental health problems. For example:

--In Richmond, Virginia, a TASC project official told us that the project does not make a special effort to screen for psychiatric problems, but these problems are easily identified during the intake screening.

--In Charlotte, North Carolina, the TASC program screens specifically for substance abusers; however, sometimes a person who is mentally ill is identified and referred to the mental health centers. The Program Director thought that the TASC program could also screen specifically for mental illness. There would only be a little extra work on the part of the screeners, and it would be no problem to add this to the interview process.

The evidence is that the TASC model would allow for the referral of the mentally ill with minimal effort. At least two jurisdictions--Iowa and Portland (OR)--have included the mentally ill in their TASC programs. A third--Milwaukee--incorporated its TASC program into a nonprofit organization which referred alcoholic and mentally ill offenders to treatment centers. Iowa expanded its statewide TASC program to include them because it realized that the otherwise narrow scope of the program would make it difficult to obtain State funds. By including referrals for the mentally ill, it secured enough funds to continue the program without Federal support.

LEAA has recognized TASC's possibilities regarding the mentally ill, but to expand the program LEAA needs the assistance of NIMH. To date, LEAA has experienced difficulty in obtaining it. The need for better interagency coordination in this and other mental health care matters is discussed in more detail on page 52.

NIC programs could do more to promote implementation of statewide standards

NIC was established within the Bureau of Prisons under provisions of the Juvenile Justice and Delinquency Prevention Act of 1974 (Public Law 93-415, 88 Stat. 1139) to improve correctional agencies and programs by providing training, technical assistance, research, policy and standards formulation, and clearinghouse services. In June 1977, NIC established an NIC Jail Center, at Boulder, (CO), to make available training, technical, and information assistance to help upgrade jail operations. As part of its effort the Center also operates a network of six regional exemplary jails, designated as area resource centers.

In summary, we found:

--The Center furnishes grants to help States implement professional standards for jails, but the grants are too limited to have a significant impact, and Center training programs have given little attention to training State personnel in the implementation of mental health standards.

--Area resource centers do not adequately address mental health services or the training of State personnel.

Center grant programs are limited and training programs give little attention to training of State personnel

The NIC Jail Center specifically encourages States to develop and implement statewide standards based on ACA and AMA standards. It has conducted several programs to encourage States to adopt professional jail standards in general, but the programs are too limited in scale to have a significant impact in bringing about more widespread adoption of standards for jail mental health services.

The programs provided only a few small grants to State agencies or appropriate organizations (such as sheriffs' associations) working with such agencies to

(1) enable States having standards that accord with national standards to take a planned approach in implementing them and (2) enable States to adopt national standards. As of July 1979, fiscal year 1979 awards involved:

--Grants of $40,000 to help implement standards in two States (South Carolina and Michigan). One had adopted the basic AMA health standards, and the other had initiated administrative action to do so.

--Grants of $50,000 to develop standards in three States.

--Grants of $35,000 and $40,000 to revise standards in two States.

One of the States that had received a $40,000 grant to help implement standards was using the funds for a demonstration project involving three jails to develop information on how to implement the standards. A State official told us the funds were barely sufficient for this purpose, and they were not sufficient to implement standards or provide related training statewide. A Center official told us in early 1980 that program activity had expanded somewhat--for example, four States were being assisted in implementing standards. She told us that if more funds were available, more States could be helped.

In addition to its grant programs, the Center conducted or assisted a variety of training activities. During fiscal years 1977-79, about 3,000 individuals, including jail administrators, sheriffs, commissioners, and attorneys, participated in management and operations training, special issue seminars, and related activities. Programs included certain particularly worthwhile features:

--They recognized the importance of using community resources in meeting jails' needs and, to this end, included joint training for teams comprised of jailers, community agency personnel, and county officials.

--As a followup, the Center provided jailers with technical assistance, including on-site visits to their jails, to help them implement what they had learned.

The programs have addressed mental health, but only in part, and have done little to train State personnel in these matters.

For example, one of the major programs--aimed at managers of large jail systems--addressed mental health care and gave information on how AMA health standards could be accomplished as part of the general, overall elements of jail operations. In fiscal year 1979, a Center program furnished grants of $25,000 to $45,000 to expand State efforts in four States to provide continuing assistance for training jailers in jail management in general. The Center also conducted a 5-day seminar for State chief inspectors of jails on standards in general.

By the way of explanation, a Center official told us that NIC did not give specific emphasis to mental health care, because it establishes programs on the basis of correctional needs as identified in public hearings, mail surveys, and grant applications, and jails had not indicated that such assistance was a priority need.

The Center has recently taken action to put more emphasis on mental illness. In September 1978, NIC, LEAA, and NIMH jointly sponsored a national workshop on mental health in jails aimed at identifying and evaluating existing service systems and at selecting systems as models. As an outcome, the Center, in late 1979, established a program of training in "Initiating and Improving Mental Health Services in Local Jails." As planned, it would provide 3-day training sessions for 50 teams of jailers, mental health system personnel, and county officials to help them develop strategies for services.

While the new program addresses standards, it is targeted at personnel of local jails, not at State personnel. A Center training official told us there was an urgent need for training seminars for State inspectors, to give States an ongoing capability, through the inspectors, to evaluate jails in terms of updated standards and to train jail personnel in how to implement them.

Area Resource Centers do not adequately address mental health care services or training of State personnel

As a further means of helping jails improve their operations, the Center, in fiscal year 1979, developed a network of six Area Resource Centers--six existing jails it engaged to serve as extensions of the Center by providing training, technical assistance, and information to jailers within their geographical area. The centers are located in States in each principal region, namely: Colorado, Connecticut, Kansas, Louisiana, Maryland, and Oregon.

The network of Area Resource Centers was not providing adequate help in the area of mental health care services. We visited two of the centers and found the following:

--One, which served about 4,000 inmates annually, had various good features--for example, inmates were adequately screened and monitored, had counseling and psychotherapy available, and could be sent to the State hospital for secure treatment. However, it had some shortcomings. There was no program, other than segregation, for mentally ill offenders who were not disturbed enough for commitment. No community aftercare connections were made for most inmates released within 3 days.

--In the other, which housed 1,750 inmates in all units, mentally disturbed inmates were placed in a rundown, overcrowded unit with no program other than medication and some pastoral counseling or in a forensic unit in a rundown ward of a local hospital, which had only a minimal program. Other than detoxification, there was no program for alcoholics.

An NIC Jail Center official advised us that shortfalls likely existed to some extent at the other area resource centers. The official explained that the jails selected to be area resource centers were selected because they were considered the best of those desiring to participate--each excelled in a number of program areas but none were exemplary in all aspects.

Recent actions by NIC and LEAA could make the Area Resource Centers more effective tools for upgrading jail mental health services. In addition to their original mission of assisting jails in their own particular areas of expertise, the centers have been given the further mission of encouraging the adoption and implementation of ACA standards--which include the basic AMA jail mental health care standards--through an accreditation process.

Six additional centers are to be developed by mid-1980. More specifically, LEAA, in July 1979, initiated an interagency agreement with the NIC Jail Center whereby LEAA will fund NIC development of six jails as Area Resource Centers. For this purpose, LEAA agreed to transfer $370,000 to NIC in the first year and, on the basis of the successful completion of objectives and the availability of funds, $360,000 for each of the next 3 years. When all centers are operating at full capacity, they will be able to provide training and technical assistance to 3,000 jail professionals annually.

LEAA undertook the action as its means of promoting the accreditation of jails based on ACA standards. The accreditation is carried out by the Commission on Accreditation for Corrections, a group funded by LEAA to accredit correctional agencies and systems.

In line with LEAA's purpose, the mission and activities of the new Area Resource Centers will emphasize the implementation of standards and accreditation--and an official of the NIC Jail Center advised us the mission of the six existing centers had been revised to correspond. Besides providing other jails with assistance in their specialty area, the centers are to serve as "accreditation models." They are to enter the accreditation process and, as a corollary, develop specific and comprehensive information packages detailing the implementation of ACA standards for jails, including information on the feasibility, methodology, cost of implementation, and related items connected with their participation in the accreditation process. They are also to

--develop the capability to provide training in meeting standards, mainly in the form of short 3- to 5-day special issue seminars, to jail staffs in their areas; and

--provide technical assistance, mainly by hosting visits of personnel from other jails, in connection with standards implementation.

Each of the existing Area Resource Centers was planning to enter or had entered the accreditation process. An NIC Jail Center official told us that the Commission on Accreditation would likely identify various deficiencies that will have to be corrected, and improvements would be achieved only after considerable work.

In our opinion, when Area Resource Centers have achieved their intended capability, they could be a useful tool in bringing jails up to modern standards in their mental health care services. However, we noted several factors that could constrain their effectiveness. Action is needed to ensure that the centers

--provide assistance specifically regarding standards for mental health services,

--assist efforts to implement statewide standards for such services, and

--make appropriate use of AMA efforts in the matter.

The NIC Jail Center has not taken action to ensure that any one of the resource centers will develop expertise for assisting jails in implementing all the important mental health and substance abuse standards. The fact that the centers are to become accredited and develop expertise in helping other jails implement jail standards for accreditation purposes does not necessarily mean their expertise will involve those of the standards that pertain to mental health care services. This is so because the centers, like other jails, need not meet all of the ACA standards to become accredited. A jail can achieve compliance for accreditation if it conforms to 90 percent of the "essential" standards (which comprise 60 percent of the total), 80 percent of the "important" standards (which comprise 35 percent of the total), and 70 percent of the "desirable" standards (the remaining 5 percent of the total).

Further, little has been done to use the Area Resource Centers as a tool for promoting State efforts to implement statewide standards. They essentially promote implementation and accreditation on a voluntary, jail-by-jail basis, and few jails have sought accreditation. In our opinion, the impact of the centers, or those that may focus on standards for mental health services, would be enhanced if they made provision for training appropriate personnel of States that show a willingness to implement statewide professional standards for these services.

We noted that the NIC Jail Center had not linked centers' activities to AMA efforts, under LEAA's SIP program, to assist the implementation of AMA jail health standards in 22 States. The benefits of AMA's experience in the matter should be input to and used by the Centers as a further means of promoting the implementation of professional standards.

ADAMHA INSTITUTES COULD DO MORE TO PROMOTE USE OF COMMUNITY AGENCIES IN MEETING INMATE NEEDS

As explained in chapter 2, jails need to utilize the services of community agencies to facilitate the provision of mental health care. But in many cases jails have not obtained these services, in part because States have done little to carry out the planning needed to ensure that community agencies are involved in meeting inmate needs.

Although NIMH, NIAAA, and NIDA have the potential to promote and facilitate more extensive involvement of community mental health and substance abuse agencies, none had encouraged or required State agencies to consider jail inmates in assessing needs and planning for community mental health, alcohol, and drug services. In addition, NIMH had not informed federally assisted community mental health centers or State agencies responsible for mental health as to how local centers could help jails provide services for inmates; NIAAA had not evaluated the effectiveness of NIAAA-assisted State programs to treat rather than jail public inebriates; and NIDA had restricted the extent to which community agencies could assist jails.

Jail inmates have received little assistance from NIMH Programs

NIMH was established to provide a focus for Federal efforts to improve the treatment and rehabilitation of the mentally ill. The Community Mental Health Centers Act (Public Law 88-164,77 Stat. 290) requires that a State agency be designated responsible for a State plan for the provision of comprehensive services for the mentally ill within the State. These plans are to, among other things, set forth a program for centers based on a statewide inventory of existing facilities and a survey of the need for comprehensive services for the mentally ill. Congressional intent was to establish a network of community mental health centers that would provide community-based mental health care throughout the Nation. While a total national network of about 1,500 centers is envisioned, about 760 were operational in fiscal year 1979. They covered about 50 percent of the population across the country.

The centers are required by law to provide a variety of comprehensive services to the geographic area they serve. Among the 12 mandated services are

--consultation and education services for courts and State and local law enforcement agencies and correctional agencies, among others;

--inpatient, outpatient, and emergency services;

--assistance to courts and other public agencies in screening residents being considered for inpatient treatment at a State facility for the mentally ill; and

--followup care for residents of their geographic areas who have been discharged from a mental health facility.

We found that NIMH had not acted to help ensure that community health agencies supported efforts to provide adequate treatment and care for jail inmates affected by mental illness. More specifically it

--had not instructed State agencies responsible for mental health planning to assess the need of the jail population, and

--had not provided community mental health centers or State agencies adequate guidance regarding assistance local centers could provide jails.

NIMH should require State agencies to consider the jail population in assessing needs and planning services

None of the State mental health plans furnished to us during our visits with responsible State officials in 1979 adequately considered the needs of the jail population. None

- --included a comprehensive assessment of jail inmates' needs--an assessment of the number of mentally ill jail inmates needing mental health services in each service area of the State, or the number having specific types of problems;
- --included data on the unmet needs of jail inmates; or
- --assessed the extent to which assistance to jails could be provided locally.

Moreover, State officials responsible for planning generally did not know the extent of inmates' needs. State officials generally told us the needs of jail inmates were not specifically included in the plans either because jail inmates were considered part of the general population for needs assessment and planning purposes or because they were a low priority population group.

An NIMH official told us that neither the law nor regulations require States to specifically address jail inmates in their statewide planning process. Although we agree that the law does not provide the authority to require the earmarking of funds to treat inmates, it does provide NIMH sufficient flexibility to require States to at least assess the needs of jail inmates in their plan formulation process. In requiring plans based on a survey of need for comprehensive services for the mentally ill, the Community Mental Health Centers Act specifies that the services to be assessed include consultation and education services for courts, State and local law enforcement agencies and correctional agencies, among others. Further the regulations specify that in determining the relative need for services, "the demographic, economic, and social characteristics of each area, including the relative size of population groups considered to be more likely than others to have a need for such services" be considered.

NIMH guidelines for the preparation of State plans had not been finalized as of September 1979, and the working draft of these guidelines being used by State agencies provided little guidance on the assessment of needs and existing resources. We think that NIMH should revise these guidelines to impress upon the State agencies the importance of assessing jail inmates' needs in the planning process. A reasonable assessment of jail inmates' needs would aid the States in properly determining priorities and planning for improvements.

NIMH has not provided community mental health centers or State agencies adequate guidance regarding the assistance local centers could provide jails

NIMH officials were not able to tell us how many community mental health centers throughout the country have provided jails with assistance in serving inmates. One official said that any assistance given jails would have been considered part of the consultation and education services. A 1-month study of consultation and education services by NIMH in 1976 showed that 9 percent of the 223,649 staff hours for consultation and education were directed toward State and local law enforcement and correctional agencies. We could not determine what portion of these staff hours were specifically directed toward jails.

We visited the centers which served three of the jails we reviewed in one State. While all of them had developed informal relationships with the jails, the services provided may not have been available to each jail inmate. One center, for instance, provided services only when the inmate was brought to the center. Moreover, two of the centers had not developed written contracts or agreements with the jail; nor had they developed policies, procedures, and guidelines specifying the range of services to be provided and the methods of service delivery. Also, these centers had not developed data on the number of inmates needing care.

Consultation and education, which are required services of the centers, could include a variety of activities to assist jails, such as:

(1) Program consultation to assist jails in planning, developing, managing, evaluating, and coordinating a program for mentally ill jail inmates.

(2) Case-oriented consultation to assist a sheriff, doctor, or other jail personnel in diagnosing and arranging for or providing services for a specific inmate.

(3) Providing information about the resources available in the community to assist the jail in arranging services for inmates and how to use these resources.

(4) Education and training for jail personnel so they can understand the nature of mental illness, identify inmates with problems, and obtain services for them.

However, NIMH has not provided this type of guidance to the centers. NIMH guidelines for consultation and education service grants are still in draft form and provide little specific guidance regarding consultation and education services for jails. They cite the pertinent sections of the law and discuss the purpose of consultation and education services, but they never specify how these purposes could be accomplished for a jail. A publication on the scope of community mental health consultation and education published in 1971 provides a more detailed description of what consultation and education is and how it works but likewise provides no specifics on how it would relate to jails.

In our view, NIMH guidance on the specific ways by which the centers could assist jails would encourage them to give formal attention to jails' needs and would better assure that the centers were cognizant of the range of services they might be able to provide.

Moreover, furnishing guidance to State agencies regarding centers' potential would encourage and facilitate needed State efforts to define community agencies' roles and assure that such agencies are aware of and responsive to jails' needs. Like NIMH, the States we visited were also unable to tell us how many local mental health centers were assisting jails or what inadequacies existed. State agencies had not provided policies, guidance, or directions to local agencies responsible for the mentally ill to clarify their roles and responsibilities for jail inmates.

The situation seems to be nationwide in scope. A 1978 study of mental health care in jails, funded by the NIC, found that few community mental health representatives had expressed interest or offered services for the jail population, and few jail managers had sought to cultivate outside agency involvement in their facilities.

NIMH is authorized to provide funding support for the centers only during their first 8 years of operation. The Congress intended that they become self-sustaining after that by charging for services provided or by seeking third-party reimbursement from private health insurers or Medicaid or Medicare. Since inmates are (1) ineligible for medical assistance under Medicaid, (2) are generally unable to pay for services they receive, and (3) generally do not carry health insurance, providing them services without providing for some other form of reimbursement could cause financial problems for the centers.

One solution might be for the jail to enter into a contractual agreement with the center providing the services. In this manner, jails would be able to assure proper mental health care, and centers would receive funds for the services they provide.

NIAAA formula grant programs for alcohol treatment services could provide greater assistance to jails

Established under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616, 84 Stat. 1848), NIAAA is responsible for developing and conducting comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abusers and alcoholics. Among other things, NIAAA financially assists States in planning for and developing local service capabilities through the formula grant program and awards special formula grant funds to States which have decriminalized public intoxication. We found that State agencies responsible for alcoholism planning had not adequately considered the jail inmate in assessing needs and planning for local services. Also, NIAAA had not evaluated the effectiveness of the special formula grant program or disseminated information on the results to encourage or guide State efforts to decriminalize alcoholism.

NIAAA should encourage State agencies to consider the jail population in assessing needs and planning services

NIAAA's formula grant program is intended to enable States to develop and implement a more comprehensive and coordinated statewide alcoholism program by developing local service capabilities responsive to the needs of the

State. NIAAA legislation provides that a State agency be designated to survey the need for alcohol abuse and alcoholism prevention and treatment services, including a survey of the health facilities needed to provide services, and to develop a comprehensive plan for meeting these needs through community services. States are to use the formula funds, generally at their discretion, to implement the State plan. In fiscal year 1978, NIAAA obligated approximately $56.8 million to States through the formula grant program, or about 34 percent of all funds expended for formula and project grants, contracts, and other expenses.

The agencies responsible for alcoholism and alcohol abuse planning in the States visited had not adequately assessed jail inmates' needs. None of the State alcohol abuse and alcoholism plans furnished to us during our visits with responsible State officials in 1979 included a comprehensive assessment of the number of jail inmates having specific alcohol problems or a comprehensive assessment of the adequacy of services being provided to inmates throughout the State. One State did include statistics on the number of individuals incarcerated or on probation/parole for alcohol-related offenses, such as "drunk and disorderly, driving under the influence and possession of unauthorized liquor." However, it did not contain data on jail inmates with alcohol problems who were arrested for nonalcohol-related offenses or data on the unmet needs of inmates. In most cases the only data included in the plans was the number of alcohol-related arrests in the State. Moreover, State officials told us they generally did not know the extent of jail inmates' alcohol problems.

Generally, the State agencies visited had not adequately considered jail inmates' needs in planning for the use of NIAAA formula funds. In some instances agency officials believed that services were inadequate or agencies responsible for local programs were not assisting jails, but none of the State alcohol plans included a comprehensive statewide assessment of the adequacy of local assistance to jails. One State plan included the results of a limited survey of local substance abuse agencies' interface with the criminal justice system. Another State plan only included a table showing the number of court programs in various areas of the State. Another State plan did not even address the issue of local services provided to the criminal justice system.

An official from one State agency indicated there was no reason to assess jail inmates' needs if you did not plan to provide services. He said the needs of jail inmates were not specifically addressed in the plan because there was no interest in serving jail inmates due to other priorities. Further, he said State laws did not require them to serve jail inmates and funding was also not available. Officials from another State said they did not feel they were responsible for assessing the needs of jail inmates in their plans or providing them services and said that Federal regulations do not require them to do so. Officials from another State said jail inmates' needs were not specifically assessed in the plan because they are considered part of the general population for planning purposes.

An NIAAA official advised us that even though NIAAA considers jail inmates as a specific population group to be assessed and served, most States overlook the jail population in their plans. He said the institute does not know the amount of formula funds used to serve jail inmates.

An NIAAA official told us the institute could not require States to earmark funds specifically to serve jail inmates, because the intent of the formula grant program is for States to use these funds at their discretion. While we agree the law does not provide the authority to require the earmarking of funds to treat inmates, it does provide NIAAA sufficient flexibility to require States to at least assess jail inmates' needs in their plan formulation process. This should be clearly specified in their guidelines for State plans. These guidelines, which had not been finalized at the time of our review, provided very little guidance on needs assessment. These guidelines suggested that States include statistics and data on the number and type of alcohol-related arrests and identify any target groups and areas in the State with unmet needs, but they did not specify that jail inmates are a likely group in need of care.

We think NIAAA should revise these guidelines and stress the importance of assessing jail inmates' needs. A reasonable needs assessment is fundamental to proper planning. States need this basic information to determine priorities and systematically and rationally plan for and provide assistance to alcohol abusing inmates.

State efforts to decriminalize public intoxication should be evaluated and lessons learned should be widely publicized

The Uniform Alcoholism and Intoxication Treatment Act, model legislation developed by the National Conference of Commissioners on Uniform State Laws, provides for the decriminalization of public intoxication and mandates services rather than jail for alcoholic persons. NIAAA provides special formula grants to assist States which have adopted the basic provisions of the Uniform Act. Its basic provisions call for

- --repeal of those portions of criminal statutes and ordinances under which drunkenness (with no accompanying criminal misbehavior) constitutes a petty offense, such as loitering, vagrancy, or disturbing the peace; and
- --commits each State to the concept of care for alcohol abuse and alcoholism through community health and social service agencies.

Each State that implements the basic provisions of the Uniform Act may receive annually a supplemental 20 percent of its formula grant allocation plus a sum of up to $150,000 for up to 6 years.

From fiscal years 1975 to 1979, NIAAA had awarded grants for over $36 million to 29 States, the District of Columbia, Puerto Rico, and the Virgin Islands, which had passed legislation in conformance with the Uniform Act. Some States, such as Delaware, Georgia, and New Hampshire, had passed the legislation, but delayed implementation. Other States had passed some portion of the legislation or a version not entirely in conformance with the Uniform Act. California's act allows each county in the State to implement the act when it has the capability to provide the services in lieu of arrest. Five of the nine States we visited had passed legislation in conformance with the Uniform Act: Illinois, New York, Michigan, North Carolina, and Wisconsin.

States have experienced a variety of successes and problems in implementing the Uniform Act. According to a 1978 NIAAA report, some States have reported an overall reduction in police workload after adoption of the Uniform

Act. The report states that in the District of Columbia, police contacts with intoxicated persons declined from 40,000 to 6,000 arrests annually, while there was a 39-percent drop in arrests in Boston. According to the same report, decriminalization also has resulted in large monetary savings. In Boston, a 1-day stay at the city detoxification center was reported to cost $28 compared to $48 a day in the city jail. In San Diego County, California, it was reported that the $125 cost per arrest to book, incarcerate, and process offenders through the courts was reduced to $35 a day to detoxify each client. Two public inebriate projects in Florida were considered to be so successful the State wanted to start similar projects in eight other cities. The NIAAA report also pointed out problem areas: funding was not always available for the treatment, public inebriates did not always accept treatment because treatment is voluntary, and there was often a shortage of vehicles and personnel to transport people to treatment facilities.

The States we visited also had a variety of experiences in implementing the legislation.

--An official from Wisconsin told us that since the State decriminalized alcoholism, detoxification centers had become overwhelmed with alcoholics. The cost of housing an alcoholic in jail was $12 a night, but the cost of detoxification was $120 a night.

--A Michigan official said the Office of Substance Abuse Services initially underestimated the number of persons who would need treatment. They estimated about 20 percent of those persons picked up would need treatment, but experience showed that about 50 to 60 percent of the persons need treatment. The office subsequently developed an action plan to assure that these people received treatment services.

--An official from North Carolina told us the number of alcohol-related arrests dropped from 56,000 to 44,000 the first year the legislation was passed, but sufficient funds were not appropriated to develop the additional detoxification and long-term care facilities needed to provide treatment.

--South Carolina repealed legislation to decriminalize public intoxication because community treatment capabilities had not been developed.

In our opinion, States could learn from the experiences of other States in implementing the act, but NIAAA has not yet evaluated the overall effectiveness of the special formula grant program. An NIAAA official told us a proposal for a program evaluation had been approved, but funds had not yet been budgeted.

Providing community treatment rather than jailing for public inebriates could reduce the burden on jails for alcoholism treatment services, and, as discussed earlier, we found that NIC Area Resource Centers and other jails visited had problems treating public inebriates. Also, the many States which have yet to enact legislation to decriminalize public intoxication may be encouraged to do so if it were determined to be successful.

NIDA assistance for jailed drug abusing offenders can be improved

NIDA, established in 1973 under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255, 86 Stat. 65), is responsible for focusing the comprehensive resources of the Federal Government on drug abuse, with the immediate objective of significantly reducing the incidence of drug abuse in the United States. To achieve this end, NIDA, among other things, provides grants to State agencies responsible for drug abuse programs to assist them in planning needed drug treatment activities and in establishing and conducting treatment programs. NIDA guidelines make provisions for State agencies to include the needs of criminal justice systems in these program planning and development efforts.

NIDA-assisted programs have made a positive contribution to improving treatment for drug abusing offenders by helping expand community-based treatment alternatives to jailing. However, the impact of NIDA assistance for such offenders has been constrained in that:

--States have not adequately addressed inmate needs in their planning process.

--NIDA has restricted the extent to which its funds can be used to provide treatment services to inmates.

NIDA needs to better assure that State agencies consider inmates in planning treatment activities

NIDA's legislation calls for designating a State agency to survey the State's need for drug abuse programs and to develop a State plan to meet those needs. Section 409 of the act authorizes NIDA to make grants to the States primarily to assist them in these planning efforts. NIDA program guidelines provide that the planning should, among other things, address the needs of the criminal justice system, which include the needs of jail inmates.

Despite the provisions of NIDA guidelines, none of the agencies responsible for drug abuse planning in the States visited adequately addressed jail inmates. Only one of the State plans included an assessment of the number of jail inmates having drug problems, and none of the plans specifically addressed the adequacy of services for jail inmates or the adequacy of local drug agency linkages with jails. The plans sometimes contained limited data, such as the number of drug-related arrests, or referred to local drug agency linkages with the courts. This limited data, however, is not sufficient for the States to identify specific gaps in services, the reasons, and ways to systematically correct shortfalls.

According to a NIDA official, NIDA personnel, in reviewing State plans, check to see whether the plans provide for efforts to meet inmates' needs--but they take no action to correct the plans if they find them deficient. The official told us NIDA sends the State a critique of the plan, which points out any shortfalls regarding efforts for inmates but does not disapprove the plan due to the shortfalls.

The official explained that NIDA did not expect State agencies to gather planning data regarding inmates' needs but only expected them to see whether the data was available. His rationale on the point was that the LEAA-assisted criminal justice agencies had primary responsibility for addressing the drug treatment needs of inmates.

NIDA policies restrict treatment of inmates within jails

Section 410 of NIDA's legislation provides funds to States and localities to, among other things, support about 95,000 "treatment slots." (The term "treatment slots" refers to the ability to treat one person for

1 year.) Treatment services are provided by local drug abuse treatment programs, usually on an outpatient basis. While NIDA-supported local programs have helped promote community-based treatment alternatives to jailing for drug abusers, NIDA policy has restricted their ability to provide treatment to inmates.

In a February 1977 letter, NIDA informed State program directors that Section 410 funds may not be used by local programs to provide treatment services to incarcerated drug abusers with the exception of the first 30 days--for inmates who were in a treatment program when arrested--and the last 60 days of incarceration. A NIDA official advised us the letter was issued to clarify NIDA policy, because NIDA had found that States had been applying such funds to prisons, contrary to earlier established policy.

In explaining the action, an official told us it had never been NIDA's mandate or intent to provide drug treatment for inmates--that assistance for jails in meeting these treatment needs was an LEAA responsibility. He said that NIDA's policy was adopted on the basis of a Special Action Office on Drug Abuse Prevention policy relating to the LEAA-initiated TASC Program. More specifically, he stated that the Special Action Office on Drug Abuse Prevention had directed that, under the program, LEAA would fund screening and referral of offenders for treatment, whereas NIDA-assisted community programs could be used to provide treatment for these offenders. NIDA interpreted the directive as meaning that NIDA, as a general policy, should restrict its assistance for offenders to community treatment and that LEAA was responsible for assistance for programs within jails.

In our opinion, NIDA's policy restriction on use of Section 410 funds for providing treatment services to incarcerated inmates is not well founded. We believe the policy that influenced its adoption did not provide a basis for NIDA's belief that LEAA was primarily responsible for funding drug treatment in jails. The TASC Program, to which the policy pertained, was intended to provide for treatment in the community as an alternative to incarceration, and thus the policy statement concerning LEAA-NIDA funding responsibilities did not specifically apply to funding treatment provided by local programs to persons held within jails.

Moreover, according to an LEAA official, NIDA's decision to restrict use of the funds was a unilateral decision by NIDA--NIDA did not coordinate or consult with LEAA in the decision. He pointed out that LEAA's ability to assist treatment services is constrained because its overall funds are limited and must be used to assist an entire spectrum of law enforcement and criminal justice activities. Since NIDA's action served to place the burden of assisting inmates largely on LEAA, we think NIDA should have coordinated with LEAA.

In one State we visited, officials were particularly concerned about the impact the restriction on Section 410 funds has on offenders with sentences longer than 90 days. For example, an inmate with a 180-day sentence would have a 3-month gap in treatment. The State appealed to NIDA for authority to provide treatment to inmates for a period of 1 year prior to release, but this request was denied.

In our report on mental health care in prisons, 1/ we recommended that the Department of Health, Education, and Welfare (now the Department of Health and Human Services) direct NIDA to remove its restriction on using Drug Abuse Office and Treatment Act funds for treating inmates in correctional institutions. The Department, however, did not concur with our recommendation. It believed that removing the restriction would seriously threaten the provision of services to individuals whose needs are currently being met. It also stated that its policy was consistent with overall Federal policy in this area.

During that review, and again after receiving the Department's comments, we reviewed the documents containing the Federal strategy for treating and preventing drug abuse. We found nothing in the strategy that stated which agencies should fund drug treatment for incarcerated persons.

We continue to believe the restriction is undesirable in that it prevents States and localities from using NIDA funds for prison and jail inmates regardless of how high a

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1/"Prison Mental Health Care Can Be Improved By Better Management And More Effective Federal Aid", (GGD-80-11, Nov. 23, 1979).

priority they feel inmates should be given. We recognized in making our recommendation that the funds available were not sufficient to treat everyone. But States should be allowed to direct their NIDA resources to inmates if they believe that inmates have the greatest need.

DEPARTMENT OF JUSTICE EFFORTS COULD BE BETTER COORDINATED WITH ACTIVITIES OF ADAMHA INSTITUTES

Some aspects of LEAA and NIC efforts relating to jail mental health care services had been coordinated with ADAMHA's NIMH, NIAAA, and NIDA. However, coordination could be improved to better assure that LEAA and NIC programs utilize the expertise of these Federal mental health and substance abuse institutes and that their activities relating to the programs are conducted on a mutually supportive basis.

We noted several activities in which coordination had been achieved. For example, LEAA and NIDA jointly funded the TASC program for diverting substance abusers into community treatment--LEAA funded screening activities, NIDA usually funded community treatment activities. Also, LEAA, NIC, and NIMH in 1978 cosponsored a Special National Workshop on Mental Health Services in Jails. But, we also found instances where efforts to coordinate had either been unsuccessful or not even initiated.

As explained on page 31, LEAA has recognized that its TASC program for diverting substance abusers to community treatment as an alternative to jailing could be expanded to include similar diversion of the mentally ill. An LEAA official told us LEAA regarded NIMH as an excellent source of funds, technical assistance, and influence in the community; and with its assistance and cooperation LEAA may have been able to include the mentally ill in the program. The LEAA official told us, however, that direct contacts with NIMH on the matter had been unsatisfactory and that LEAA had been working with the National Coalition for Jail Reform to help influence NIMH to cooperate. In response to our inquiries, officials of the National Coalition advised us they had met with NIMH officials several times, starting in June 1979, in an attempt to obtain better NIMH involvement, primarily using NIMH-assisted community mental health centers to provide alternatives to jailing of the mentally ill. Our review of related documents the Coalition made available at our request indicated that as of early 1980 only limited progress had been made.

In April 1980, an NIMH official agreed that NIMH had been slow in responding to the Coalition's efforts. He advised us NIMH had now appointed an individual to serve as liaison with the Coalition, LEAA, and NIC. An NIMH-LEAA meeting was to be arranged to explore the problem of the incarcerated mentally ill and possible actions, programs, or funding initiative by each agency.

The NIC Jail Center coordinated with NIMH to identify problems, share information, and develop plans. But it had not made an effort to involve NIAAA and NIDA in the center's training and technical assistance programs. Since these programs are intended, in part, to help jails implement professional standards that include standards for substance abuse services, they could benefit from NIAAA and NIDA involvement. Examples of how we think they could potentially be involved follow.

NIAAA administers programs to provide project grants for the treatment and rehabilitation of special target populations. Two of the programs were directed in part at assisting alcoholism treatment services for inmates or persons diverted from jails to community programs. The Criminal Justice Alcoholism Program concerns the entire range of persons within the criminal justice system who were charged with or convicted of crimes. As of December 31, 1979, 12 projects were being funded. The Public Inebriate Program was directed at individuals with public intoxication problems, and 24 projects were funded as of December 31, 1979. In our opinion, the resources involved in these programs would have had a wider impact in helping improve services for jail inmates if NIAAA had used them for alcoholism treatment demonstration projects operated in conjunction with NIC's jail Area Resource Centers. Also, NIAAA had established a National Center for Alcohol Education for the purpose of developing training and education materials. An official advised us he thought the Center could be helpful to the NIC Jail Center in alcohol training efforts.

NIAAA officials agreed there should be coordination with NIC. In this regard, a Federal Interagency Committee on Alcoholism has been established that included representatives of LEAA and other agencies, but neither the Committee nor subcommittees included an NIC representative. The Committee's executive secretary agreed NIC should be represented and that NIC and NIAAA staff should get together.

NIDA's Criminal Justice Branch provides limited technical assistance to State and local criminal justice systems, primarily to improve coordination between those systems and drug treatment systems. The assistance includes information, suggested strategies, and consultant services. Although the program has assisted courts and probation systems to divert drug abusers into treatment as an alternative to jailing, it has done little to help jails improve treatment services for inmates. However, the branch chief told us NIDA is aware that jailers increasingly want technical help in the matter and that it plans to hold meetings involving ACA, NIC, and correctional officials to determine jails' needs and the part NIDA could play in meeting them. Since NIC Jail Center training programs include technical assistance, their effectiveness as regards drug abuse services could be increased if they were linked with NIDA's technical assistance efforts.

CONCLUSIONS

Although achieving improvements in mental health services for jail inmates is primarily a State responsibility, Federal assistance could help to encourage and facilitate such efforts.

The Department of Justice could make greater provision for training State personnel to enhance States' capability to help jails implement professional standards on a statewide basis. ADAMHA's mental health and substance abuse institutes could play a much more effective role by giving greater attention to promoting State efforts to ensure that community service agencies are utilized in bringing inmate services up to accepted standards. The institutes could also take more vigorous action to encourage State agencies to assess inmates' needs in planning statewide mental health and substance abuse services.

In addition, Department of Justice assistance programs could be better coordinated with related activities of ADAMHA and thereby provide greater assurance that Federal resources are being used to optimum effect. Insufficient action has been taken to define roles, determine needs, and identify ways whereby agencies' resources can be applied on a mutually supportive basis.

RECOMMENDATIONS

We recommend that the Secretary of HHS and the Attorney General require the Administrators of LEAA and ADAMHA and the Director, NIC, to jointly:

- --Establish a mechanism for continuing coordination among LEAA, NIC, and the HHS institutes to better assure their efforts regarding mental health care for jail inmates are directed towards common goals and are mutually supportive.

- --Define and agree upon the agencies' and institutes' respective responsibilities and roles in meeting inmates' needs and, as a corollary, develop a joint strategy for their assistance efforts.

We also recommend that the Attorney General:

Require the Administrator, LEAA, to:

- --Include in the Standards Implementation Program provision for training of State personnel responsible for training local jail staff in order to assist States in achieving an ongoing capability to help individual jails meet professional standards statewide.

Require that the Director, NIC, instruct the NIC Jail Center to:

- --Make provision for training State jail inspectors in mental health services to assist in giving States an ongoing capability to evaluate jails in terms of professional standards and to help individual jails in implementing them.

- --Establish a program of demonstration and training in the implementation of professional standards for mental health care services in some, and eventually all, jail Area Resource Centers.

- --Ensure that the jail Area Resource Centers, in connection with the above, draw upon the experience acquired by AMA in AMA's LEAA-assisted project to promote the implementation of jail health standards.

Require the Director, U.S. Marshals Service, to:

--Ensure the Service's jail inspectors are adequately trained in professional standards for jail mental health care services, as a means of assisting their implementation in local jails.

We also recommend that the Secretary, HHS:

Require the Administrator, ADAMHA, to:

--Direct NIMH and NIAAA to revise guidelines for comprehensive statewide mental health and alcoholism plans to make it clear that State agencies should assess the needs of jail inmates in the planning process.

--Direct NIMH to furnish guidelines to community mental health centers and State agencies responsible for mental health that specifically describe the ways in which centers could assist jails.

--Direct NIAAA to evaluate its program to assist States that adopt provisions of the Uniform Alcoholism and Intoxication Treatment Act and ensure that program results are made known to other States.

--Strengthen NIDA procedures for reviewing State drug agencies' comprehensive plans to ensure that the drug treatment needs of jail inmates are considered.

AGENCY COMMENTS

The Departments of Justice and Health and Human Services commented on a draft of this report by letters dated September 24, 1980, and September 22, 1980, respectively. (See app. I and II.)

The Department of Justice stated that the report presented a fairly thorough critique of mental health care conditions in State and local jails and provided good insight into the problems of providing mental health care to jail inmates. It stated that it was committed to improving mental health care for jail inmates and that every effort would be made to

- --encourage States to adopt and implement statewide mental health standards, and

- --provide guidelines and assistance directly to jails to advance the upgrading of their services to meet these standards.

The views of the Department of Justice on the matters discussed in this chapter are quite clear, and we found few areas of disagreement. The Department does, however, make several references to our "more training is needed" approach and states that it is not naive enough to assume that training is the only answer or even the most significant area of action required. We are not that naive either.

We agree that the problem of delivery of mental health services to jail inmates has no simple solution, and we do not advocate increased training as the single answer. Training is necessary, but other actions, such as interaction between the criminal justice system and community service agencies, are also needed before the problem can even be adequately addressed. The Department also states that jailers need services through which detainees can be effectively offered the mental health services they require. We agree, but we also believe that the extent to which service delivery gaps exist will only be identified if the criminal justice system and the community are interested in improving jail mental health services and work together to do it.

We have clarified our recommendation to the Department concerning the provision of training to jail inspectors. The NIC Jail Center provided training to State jail inspectors which addressed jail standards in general, and training to local jail managers which, in part, addressed mental health, and our description of NIC activities in chapter 3 specifically cited these efforts. Our point was that the center had given limited attention to training State personnel in mental health services so as to give States an ongoing capability to evaluate jails in terms of updated mental health standards and to train jail personnel in how to implement them. Regarding NIC, it should be noted that the Department did not comment on our recommendations concerning jail Area Resource Centers.

The Department stated that it considered our recommendation that LEAA provide for training of State personnel to be realistic and deserving of LEAA's support, but it pointed out that the LEAA program was being phased out of existence. We are making the recommendation because the Congress has not yet officially acted to terminate LEAA funding. If and when that occurs, alternative sources of funding for all of the LEAA initiatives discussed in this report will have to found if they are to continue.

The Department of Health and Human Services stated that it will review present and future activities to assure that emphasis on jail mental health care is ongoing and persistent and that strategies are jointly developed with other Federal and State agencies. Among other things, the Department stated that it would:

--Review the Federal agency coordination mechanisms currently in existence with a view toward modifying those found to be inadequate.

--Revise the guidelines for statewide mental health plans to emphasize consideration of the needs of jail inmates.

--Evaluate the activities being conducted under the Uniform Alcoholism and Intoxication Treatment Act and make this information available to all the States.

The Department concurred in principle with our recommendation that it strengthen NIDA's procedures for reviewing State drug agencies' comprehensive plans to ensure that the drug treatment needs of jail inmates are considered. The Department stated NIDA would encourage State agencies to include this group, but it pointed out that the legislation authorizing the programs does not provide for earmarking of funds for specific purposes or groups. We are not suggesting that funds be earmarked. Our position is that a plan cannot be comprehensive unless the needs of jail inmates are considered. States need this information in order to be sure that they are directing funds to areas of greatest need, and NIDA has the authority to require them to obtain it.

In a draft of this report, we stated that NIDA policy required local drug abuse treatment programs supported by NIDA funds to make available up to 10 percent of their treatment slots for drug abusers referred from the criminal justice system. We took the position that this was a limitation on the number of slots the programs could allocate for such abusers, and we recommended that NIDA remove the limitation so as to permit States and localities to allocate slots as they deemed warranted. We based our description of NIDA's policy on NIDA documents, including a statement by an official before the National Advisory Council on Drug Abuse entitled "NIDA Policy on the Treatment of incarcerated Individuals Through the Use of NIDA Federal Treatment Slots."

After receiving the Department's comments, we obtained further information which showed that the policy pertains only to the percentage of treatment slots that programs must make available on a priority basis and does not prohibit programs from allocating additional slots to criminal justice referrals if they choose to do so. Accordingly, we have deleted our discussion and related recommendation on this matter.

The Department also included technical comments relative to the Federal policy on the treatment of incarcerated offenders. We are basically in agreement with the strategy, but we still do not understand the rationale for requiring an individual to be physically in the community in order to receive treatment through NIDA. The expansion of NIDA's role to include helping individuals incarcerated within a community should be given close scrutiny.

The Department concluded its comments by stating that the issues need to be continually examined and addressed by both the legislative and executive branches of Federal, State, and local government. We concur.

CHAPTER 4

THE FEDERAL GOVERNMENT SHOULD IMPROVE SERVICES IN ITS OWN FACILITIES

The Federal equivalents of local jails are the Bureau of Prison's three Metropolitan Correctional Centers (MCCs). The two MCCs we visited--New York and Chicago--did not always adequately screen inmates to identify their mental health needs or provide for adequate treatment. In addition, we found certain elements in the management of the MCCs' mental health care systems that needed improvement.

MCCs SHOULD IMPROVE MENTAL HEALTH SERVICES

MCCs should improve their mental health care services by taking steps to better assure that all inmates' needs are identified. MCCs should also provide for better care of inmates with mental health problems. We found that neither of the MCCs visited adequately provided for treatment of inmates with behavioral disorders. And, contrary to ACA standards for jails, neither had a program for alcoholism, and one did not have a program for drug addiction.

MCCs do not always adequately identify inmates' problems

Despite established initial screening procedures, the MCCs did not always adequately screen incoming inmates to identify mental health problems. Moreover, comprehensive health appraisals were not performed on all inmates within 14 days of admission.

According to ACA jail standards, all inmates should be screened upon admission to the facility to identify, among other things, mental health problems. This initial screening should include an inquiry into current illnesses and health problems, mental status, and behavioral observation to identify problems requiring immediate attention and prevent occurrence of further problems such as suicides or assaults.

In accordance with Bureau policy, the MCCs visited had established appropriate procedures to initially screen incoming inmates. Physician's assistants were required to observe the inmate, inquire into possible problems during the initial medical examination, and refer inmates with potential problems to the psychiatrist or psychologist for further examination. However, MCC personnel indicated these procedures were not always adequately followed when a large number of new inmates arrived at one time. In substance, they told us that, due to lack of a sufficient number of physician's assistants, less than the normal time was applied to the initial examination on peak workload days, and the mental health screening was less than thorough or was cursory. Thus, as we see it, identification of mental health problems was compromised for expediency in completing medical examinations. An official of one MCC told us these peak periods occurred several days each week. An official of the other MCC said they occurred only about twice a month.

Mental health personnel at both MCCs agreed that the situation was less than desirable because--as our psychologist observed--inmates with problems could go undetected until their problems became acute.

ACA standards and Bureau policy also require that a comprehensive health appraisal be completed for each inmate within 14 days of admission. According to an official of the group that developed it, the ACA standard is intended to ensure that all inmates remaining in jail on the 14th day have a completed appraisal and thus does not require an appraisal of inmates released before that point. The appraisal provides an important means of identifying inmates' mental health needs. The Bureau's policy specifies that the comprehensive health appraisal include an appraisal of the inmates' mental status and, if appropriate, a psychiatric evaluation.

We found neither MCC visited was adhering to Bureau policy in the matter. MCC officials advised us the appraisals were made only for inmates sentenced to the MCC for 6 months or more and those identified as having health problems during the initial screening. Inmates awaiting arraignment, trial, or sentencing, or with sentences of less than 6 months did not routinely receive an appraisal.

A Bureau medical official told us MCCs were not adhering to the policy for reasons of practicality. As hindering factors he cited high inmate turnover and inmate unavailability due to court appearances. We recognize that it may be administratively challenging to identify and refer for appraisal all inmates remaining in MCCs for 14 days or more. However, ACA has termed the ACA standard involved "essential," and an official of the group that developed the standard advised us it had been tested in large and small jails throughout the country and found to be realistic. He told us most jails found it was not impractical to meet.

MCCs did not adequately provide for treatment of inmates having behavioral disorders

Neither the New York nor Chicago MCC was providing adequate treatment services for all inmates having behavioral disorders. Methods used to treat behavioral disorders are aimed at behavior modification--to help patients understand why they act as they do, and convince them to act otherwise. The treatment methods commonly used are individual and group psychological counseling sessions.

The Bureau's policy in the matter is to treat those inmates who are dangerous to themselves or others, or who request help. We found that treatment services at MCCs were largely crisis-oriented in that they concentrated on inmates who were clearly disturbed. Only limited services were available to inmates whose problems were less overt or not in the acute stage. At the New York MCC the professional mental health staff was unable to treat all inmates having behavioral disorders.

- --The staff had no time to treat repeat offenders whose problems appeared to be psychologically related.
- --Sentenced inmates did not appear to receive any attention unless they became disturbed.
- --Anxious offenders may or may not get psychological assistance depending on whether professional staff was available. The MCC psychologist told us that about one-half the pre-trial prisoners had requested counseling but were not provided with it.

MCC officials explained that a lack of funds and, consequently, manpower were persistent problems. The MCC's psychiatrist and psychologist did whatever they could to help inmates under the theory that a little help was better than none.

The Chicago MCC's staff was also constrained in its capacity to adequately treat all inmates having behavioral disorders. On the basis of information obtained at the MCC and observations made by our psychologist, we noted that:

--The psychiatrist was short of time for extensive treatment of referred inmates.

--The psychologist had time for only very limited psychological counseling of sentenced inmates.

MCC officials and staff responsible for mental health care realized their service limitations and attributed them to lack of funding and manpower.

Drug and alcohol programs do not meet standards

MCCs offered drug and alcohol abusers and addicts little in the way of programs meeting nationally accepted standards.

ACA standards require that:

--Alcohol and drug abusers and addicts be detoxified under medical supervision.

--A special program be available for abusers and addicts and, as part of the program, individual treatment plans be developed.

Both MCCs provided medically supervised detoxification. However, they had no special programs other than one operated by a private drug-oriented group which came to the New York MCC but only to assist inmates who were in the pretrial stage or nearing release.

In July 1979, the Bureau revised policies and procedures to reflect the recommendations of a Task Force that was appointed specifically to review its drug and alcohol programs. The Task Force's recommendations included establishing standards for staffing, training, program content, inmate completion of treatment, and evaluation of program and inmate performance. A Bureau official told us MCCs were subject to these revised policies and procedures, but a policy change was expected to be issued which would exempt MCCs from complying with these requirements. The official told us the reason was that inmates usually stayed only a short time at MCCs--an average of about 30 days.

According to professionals responsible for mental health care, however, inmates with problems such as drug or alcohol abuse or addiction should be furnished program services to deal with the problems and provide a basis for later treatment in the community. Adequate programs encourage inmates to seek help, provide a diagnosis of their problem, and institute a remedial effort that can be continued upon release. A policy change should not be implemented without recognizing that MCC inmates need an alternative source of access to such programs.

IMPROVEMENTS ARE ALSO NEEDED IN THE MANAGEMENT OF MENTAL HEALTH CARE SERVICES

Many of the shortfalls in mental health services at the MCCs were attributed, in part, to funding constraints and personnel shortages. But we noted that deficiencies existed in the management of their mental health care delivery systems.

- --Mental health staffs were underutilized due to a lack of clerical support for professional personnel and a lack of continuing training for supportive personnel.
- --Records of psychological contacts were not being maintained.

Correcting management shortfalls would not only improve mental health care services but facilitate more effective utilization of existing resources.

Professional mental health staffs should be better utilized

We found that MCCs could increase the professional staffs' time available for treatment activities by providing them with clerical support and increase the efficiency of staff involved in identifying inmates with mental health problems by providing ongoing reinforcement training.

The Bureau's Psychology Service Handbook provides that, whenever possible, an institution's Psychology Service should have a full-time secretary or clerk for record maintenance, typing, and similar duties. It further provides that, if none is available, specific written agreements should allow for the absorption of these duties by other administrative staff in the institution.

MCCs were not adequately meeting the professional mental health staffs' clerical needs. At both MCCs, the psychiatrists and psychologists had either little or no clerical support and had to do much of this work themselves. Obviously, performing clerical duties reduced the time available for rendering their professional services to inmates as well as for other important duties such as training of MCC staff, and performing court-ordered competency evaluations. The professional staffs told us they could do nothing to alleviate the situation.

Ongoing training would improve supportive staff utilization

Management could improve mental health staff utilization in some cases by providing ongoing psychological training to physician's assistants. ACA standards require that facility personnel be trained in recognizing symptoms of mental illness. MCCs provide all new personnel with 80 hours of basic training which addresses, in part, mental health problems and recognition of their symptoms.

The MCC psychologists are concerned about the staffs' psychological awareness and perspective and meet with correctional counselors weekly to discuss and reinforce aspects of mental health and how to handle mentally ill inmates. At one MCC, the psychologist assists the warden in selecting new staff so that people with more sensitivity toward inmates' mental health needs can be obtained.

However, the MCCs do not provide physician's assistants with such ongoing psychological reinforcement training, although primary reliance is placed on them to identify inmates' mental health problems during initial screening. Since some physician's assistants had as little as 4 months of academic training of which varying amounts may have pertained to mental health, psychological reinforcement training for physician's assistants could help them maintain their awareness and perspective of mental health problems.

Psychological treatment contacts should be documented

Psychological treatment contacts made by psychologists were not usually recorded. Consequently, the potential for breaks in continuity of treatment and duplication of effort exists at the MCCs.

American Psychiatric Association and American Psychological Association standards both call for documentation of all significant information on the mental health treatment of an individual. The information includes the diagnosis, treatment planned, treatment given, and the results.

Adequate records of psychiatric and psychological treatment contacts are essential for providing continuity of effective care and preventing duplication of effort. Circumstances and conditions under which mental health care services are provided often change. Inmates undergoing treatment may be transferred, and mental health staff may experience turnovers in personnel. In both cases, incomplete records could cause a break in continuity because, upon transfer, the succeeding mental health staff would not know precisely what treatment had been given and what treatment was still needed--without a duplicative examination. Turnover in personnel would have the same effect if the records were incomplete.

However, the Bureau's Psychological Service manual does not require that psychological treatment contacts be recorded in a psychological file. At the Chicago MCC, the psychologist did not make a record of his psychological contacts in the medical records and did not maintain separate psychological files on each inmate. He used "Inmate Request To Staff Member" forms given him by inmates requesting to see him or personal notes to arrange and manage his appointments. These were subsequently filed in his desk for reference. At the New York MCC, both the psychologist and the full-time temporary research psychologist rarely recorded their psychological contacts in the medical file and did not make notes most of the time. The psychologists explained that they had no time and were also concerned about the confidentiality of such records.

CONCLUSIONS

The Bureau should make sure that new inmates receive an adequate initial screening to identify their mental health needs so appropriate treatment can be given and that the pretrial inmates in the MCCs for prolonged periods receive a full health appraisal. The Bureau should also assure that existing management deficiencies in the MCC mental health care delivery systems are corrected, and it should upgrade its care for inmates with behavioral disorders and substance abuse problems to comply with established policies.

RECOMMENDATIONS

In order to improve mental health care services to inmates in Federal MCCs, we recommend that the Attorney General require the Director, Bureau of Prisons, to:

--Take appropriate actions to assure inmates' mental health problems are adequately identified during initial screening and upgrade behavioral disorder treatment services to meet established policies.

--Take action to assure that MCCs routinely identify and refer for comprehensive health appraisals inmates who will be in the MCCs at least 14 days and provide such appraisals within that period.

--Provide MCC inmates with access to adequate substance abuse treatment programs.

--Increase the time available to professional mental health personnel for professional duties by giving greater priority to providing them with full-time clerical support.

--Use staff more effectively by ensuring that appropriate ongoing psychological reinforcement training is provided to physician's assistants engaged in mental health care problem identification.

--Require the establishment of a psychological file for each inmate identified as mentally ill and require recording of psychological diagnoses, treatment needed, treatment provided, and results.

AGENCY COMMENTS

The Department of Justice stated that, due to the very short stay of the residents of the MCCs and the extremely high turnover rate of their populations, there is no rational basis for holding such facilities accountable for not running the type of mental health program found in long-term institutions. The Department stated that the programs at the MCCs are designed primarily for offenders completing short sentences who have no major medical or psychological needs and that the programs at MCCs emphasize short-term psychotherapy and crisis intervention, both leading to referral to community-based resources for follow-on continuity of treatment.

We do not believe that prisons and jails ought to have similar mental health care delivery systems, and we encourage the use of existing community-based resources. But the Department should not lose sight of the fact that many of the residents of MCCs who need mental health care do not qualify under the Bureau's present program design criteria and are not receiving help while incarcerated. Also, inmates do not necessarily stay in MCCs for very short periods of time. Some are there for 1 year.

Because of such factors as the high turnover of many residents and the inability of MCCs to provide treatment for all residents requesting help, we see community-based facilities as a necessary ingredient to a successful jail mental health care program. We think that the Bureau should use them not only for referrals, but also within the MCC. For example, the Department cites community-based facilities as a source for follow-on continuity of treatment and uses the excellent alcohol treatment programs in the Chicago metropolitan area as justification for not having such programs at the Chicago MCC. But we found no evidence indicating that inmates had access to such programs during their periods of incarceration. That same situation holds true for inmates needing other types of assistance that MCCs are unable to provide. Why not encourage community-based agencies to bring a component of their program into the MCC? This would enable inmates to receive services earlier, save the institution the cost of establishing its own program and, possibly, provide inmates with a better chance of seeking treatment after their release. If Chicago has excellent alcohol programs, maximum use should be made of them.

The Department states that the MCCs have developed a fairly sophisticated screening program for all newly committed inmates. Our problem was not with the program, but, rather, with the fact that all inmates were not being adequately screened. Mental health personnel at both MCCs agreed that the situation was less than desirable.

The Department concurs in our assessment that professional staff are required to spend time in nontreatment-related activities due to a lack of clerical support, but, in view of current budget restraints, it states that there does not appear to be any foreseeable means of resolving the problem. Since the utilization of existing clerical staff was not a part of our review, we are unable to comment on this matter further. But since the Department points out that six psychology positions are being deleted in the 1982 budget, it is obvious that any help that could be provided by existing clerical staff would help to ease the impact of this reduction. Also, the Department's comment about our criticizing the mental health staff for training MCC staff is not a correct interpretation. We were citing training to show how busy these individuals were. Our problem is centered around the clerical duties the staff is required to perform, and this matter has been further clarified in our report.

Finally, the recommendation on training contained in our report is based on our observation that ongoing training is provided to correctional counselors but not to physicians' assistants. We believed that training should also be offered to that group.

U.S. Department of Justice

Washington, D.C. 20530

SEP 2 1980

Mr. William J. Anderson
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

This letter is in response to your request to the Attorney General for the comments of the Department of Justice (Department) on your draft report entitled "Jail Inmates Are Not Being Provided Adequate Mental Health Care: More Effective State and Local Action Is Needed."

In general, the report presents a fairly thorough critique of mental health care conditions in State and local jails and provides good insight into the problems of providing mental health care to jail inmates. In fact, the report documents problems which long have been concerns of the Law Enforcement Assistance Administration's (LEAA) justice assistance program. As the report notes on pages 22 and 25, LEAA has used discretionary funds to significantly assist the development and implementation of uniform professional standards for jails, and the Treatment Alternatives to Street Crime program model has already been adapted to support screening and referral of jail inmates who are mentally ill, as well as drug abusers.

Although not specifically mentioned in the draft report, LEAA's National Institute of Justice (NIJ) has also contributed to the formation of policy recommendations suggested by the General Accounting Office (GAO). In fiscal year 1978, NIJ was co-sponsor of a conference on the need for improved mental health services in jails along with the National Institute of Corrections (NIC) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Current LEAA, NIC and ADAMHA programs are in part based on the conclusions of that conference. In addition, NIJ has sponsored research in correctional standards, and an NIJ sponsored survey of the adequacy of prison and jail facilities is expected to contribute to the further development of the coordinated programs of NIC, ADAMHA and other Federal agencies. The fiscal year 1978 conference produced a research agenda which NIJ will continue to address in fiscal year 1981. The draft of NIJ's fiscal year 1981 research plan calls for further research in both correctional standards and jail facilities. In keeping with the agenda developed at the conference, it is anticipated that at least one jail research project will be in the mental health area. NIJ's draft plan was reviewed by LEAA, NIC, ADAMHA and the Bureau of Prisons (BoP) to ensure that research is linked to action programs. The report does not note, however, the LEAA funded public defender program, which provides for screening at intake to identify offenders whose offenses are related to mental health problems.

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In the context of program continuation, GAO's recommendation that the Correctional Standards Implementation Program be modified to include provisions for training State jail inspectors and other appropriate State personnel is realistic and deserving of LEAA's support. However, the entire LEAA program is now being phased out of existence. Accordingly, the report's primary contribution from LEAA's perspective may be to highlight roles which ADAMHA should assume and the need for closer liaison with NIC so that progress in meeting the mental health care needs of jail inmates will continue with appropriate Federal support and assistance.

Unfortunately, the problem of delivery of mental health services in jails is not one with simple solutions. The fact that jails are under the administrative structure of State and local jurisdictions prohibits the Federal government from mandating the application of funds or the amount and direction of effort to be devoted to the mental services area. The flow of dollars from the Federal government to State and local correctional systems is immensely complicated. While guidelines and preferred standards of operation have in fact been created through numerous Federal initiatives, such as LEAA grants to the Commission on Accreditation for Corrections, standard-setting and compliance is problematic. Mental health services represent just one area in which a Federal priority cannot easily be translated into local compliance. Jails are, most often, local facilities, operated by county and city governments. The main intent is detention, and secondarily the serving of short sentences. A treatment orientation, while a correctional goal, is not common to these jails or holding facilities. However, a public defender program which includes advocacy at intake can help identify offenders whose offenses are related to mental health problems.

Specifically, 40 percent of jail inmates have not been convicted and are not even subject to treatment or programming, but mental health problems can be identified at intake if screening is provided. State correctional institutions can more responsibly be held accountable for better mental health and other treatment programs. The jail is often controlled, under county or municipal government, by a sheriff, elected or appointed, whose orientation is law enforcement, not treatment or rehabilitation.

The delivery of mental health services in jails is more involved than GAO's "more training is needed" approach suggests. There is at present no unified system, no integrated approach, either to administer mental health services, or to insure the adoption of preferred standards. At present, the accreditation process is a voluntary one. Even more crucial than training jailers to deal with the mentally ill is the need to insure that persons determined to be mentally ill are treated by the State and local mental health systems. For a variety of reasons, more persons are entering jails who historically would have been treated by mental health professionals. Jailers now are faced with a more important issue than training their personnel to diagnose and counsel--they need services to which detainees can be effectively offered the mental health services they require. The draft report does not address this core issue.

We agree with GAO's statement that States need to make a greater effort to improve mental health conditions in local jails, but we also recognize that health care services, even when State funded, are most often administered locally. This means the State is in a position to encourage local mental health units to provide care to jail inmates, but probably cannot mandate that such services be provided unless the mandate falls within the Federal guidelines that States must follow. While encouragement is desirable, it will have little impact unless it can be associated with the expenditure of program dollars. We also recognize, as does GAO, that a free person's mental health problem is real and visible, but a jail inmate's mental health problem evaporates in a maze of bureaucratic red-tape, even though he or she would be eligible for service in the free population. Jail inmates with mental health problems are also invisible to those at the local level who are responsible for service delivery because they are literally off the street and out of sight. To the local jailer, however, jail inmates with mental health problems are visible and problematic. Unfortunately, jailers do not have ready access to local mental health services. They need help in establishing linkage or formal agreements between the service agencies and the jails so that mental health care can be provided.

State supervision and assistance for training jail personnel is a major part of NIC's capacity building efforts. We feel, just as GAO does, that State leadership should and can improve jail conditions, including mental health. We also hope that this initiative will help build bridges within the community between those who are responsible for mental health services at the State and local level and those who are responsible for operating jail programs, but we are not naive enough to assume that training is the only answer or even the most significant area of action required.

We also agree that the Federal government can do more to promote State action. NIC presently has a joint grant with the National Institute of Mental Health (NIMH) to encourage better coordination between mental health units and jails and thus provide better services to jails. Unfortunately, it is a very modest grant, hence its impact is limited, as is NIMH's interest in the effort.

Contrary to the statement on page iii of the Digest, NIC does provide regular programs to train jail inspectors, plus a management training program that includes four courses on mental health problems in jails. Guidelines from NIMH would be helpful in carrying out these training efforts. In fact, we would encourage and solicit further NIMH help in this area.

Unfortunately, this report sheds little light on the solutions to the real problem identified. Even if jail personnel are trained to identify persons with mental health problems, they have no resources or places to which these troublesome inmates can be referred. The mental health staff sees these inmates as not amenable to treatment, unresponsive, noncooperative, etc., hence they do not fit into a traditional mental health program. Yet, these same inmates tend to be the problem inmates who commit lesser crimes and end up staying in jail longer because they (1) cause problems in jail, and (2) do not generally have the same opportunities for prerelease programs except where there is an advocacy program carried out by a public defender unit.

NIC will continue to emphasize training in mental health for policymakers, State inspectors and jailers. We recognize that it will be through NIC's State capacity building efforts that long range progress will be made--that is, the building of linkage and cooperative efforts between jailers and their local mental health services including support by appropriate State agencies.

The Department also agrees that the U.S. Marshals Service (USMS) is in a unique position to assist local jails in improving mental health care services. As the report indicates, actions are being initiated to take advantage of this unique opportunity, but budget constraints have temporarily hampered the Department's efforts to establish training programs for USMS enforcement specialists in mental health care. The training programs are designed to instruct enforcement specialists how to do in-depth health care analyses of jails using standards developed by the American Medical Association. As USMS field staff receive the necessary mental health services training, their inspection program will be modified to include assistance to jails in implementing professional standards for mental health care services.

Chapter 4 of the draft report critiques the mental health programs at two facilities in the Federal Prison System--Chicago Metropolitan Correctional Center (MCC) and New York MCC. GAO maintains that "The two MCCs we visited . . . did not always adequately screen inmates to identify their mental health needs or provide for adequate treatment."

The general context of this chapter suggests that GAO does not fully appreciate the difference in functional design between operating a short-term detention facility and managing a prison. Due to the very short stay of the residents at the MCCs and the extremely high turnover rate of their populations, there is no rational basis for holding such facilities accountable for not running the type of mental health program found in long-term institutions.

The programs at the MCCs are designed primarily for offenders completing short sentences who have no major medical or psychological needs. Both the architecture and the staffing pattern of the MCCs are structured in conformity with this principle. The programs at this type facility emphasize short-term psychotherapy and crisis intervention, both leading to referral to community-based resources for follow-on continuity of treatment. Thus, their objective is to promptly deliver appropriate mental health services to those inmates with moderate to severe needs for this type intervention.

Counter to GAO's contention, the MCCs have developed a fairly sophisticated screening program for all newly committed inmates. GAO acknowledges that disturbed inmates receive attention but criticizes the BoP because the "MCCs did not adequately provide for treatment of inmates having behavioral disorders." This is neither the designed function of the MCC, nor is it possible in light of the enormous number of short-term individuals--both sentenced and unsentenced--it is required to process. Thus, GAO is holding BoP at fault for not meeting an inappropriate standard.

Counter to GAO's contention that "MCCs offered drug and alcohol abusers and addicts little in the way of programs meeting nationally accepted standards," both the Chicago and New York MCCs do make programs available to inmates in these areas. Chicago maintains that an "on-site alcohol program is not feasible nor desirable due to the availability of several excellent alcohol treatment programs in the Chicago metropolitan area." Indeed, GAO might have criticized Chicago if it did have an on-site program since it would then be needlessly--and expensively--duplicating an already available program.

There appears to be a contradictory message involving two successive paragraphs on page 51. In paragraph three, BoP's mental health staff is criticized for being involved in the administrative task of training the MCC staff. In paragraph four, GAO states that "Management could improve mental health staff utilization in some cases by providing ongoing psychological training to physician's assistants." Whatever the message, BoP recognizes that there is a need for such training, and the mental health staff plans to continue to provide such training to the extent they are able to do so. In terms of administrative tasks, GAO is correct in its assessment that professional staff are required to spend time in nontreatment related activities due to a lack of clerical support. GAO offers no solutions and, in view of current budget restraints, there does not appear to be any foreseeable means of resolving the problem. Indeed, in the 1982 budget, not only are no clerical positions being added, six psychology positions are being deleted.

In conclusion, we would like to point out that although improving mental health care in locally-operated jails is not primarily a Federal responsibility, the Department remains committed to providing financial and technical assistance to improve mental health care services for jail inmates. Every effort will be made to (1) encourage States to adopt and implement statewide mental health standards and (2) to provide guidance and assistance directly to jails to advance the upgrading of their services to meet these standards.

We appreciate the opportunity to comment on the draft report. Should you desire any additional information, please feel free to contact me.

Sincerely,

Kevin D. Rooney

Kevin D. Rooney
Assistant Attorney General
for Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Washington, D.C. 20201

SEP 22 1980

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Jail Inmates Are Not Being Provided Adequate Mental Health Care: More Effective State and Federal Action Is Needed." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Inspector General (Designate)

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "JAIL INMATES ARE NOT BEING PROVIDED ADEQUATE MENTAL HEALTH CARE: MORE EFFECTIVE STATE AND FEDERAL ACTION IS NEEDED"

GENERAL COMMENTS

The general tenor of this General Accounting Office (GAO) draft report focuses attention on a poorly served segment of our society. The Department continues to address the adequacy of mental health resources made available to jail inmates, and has attempted to influence States and localities positively through planning guidelines and other mechanisms; unquestionably, more remains to be done. The Department will review present and future activities most carefully to assure that emphasis is ongoing and persistent, and that strategies are jointly developed with other Federal and State agencies.

At the same time, as the draft report recognizes, we are not empowered to do more than urge and monitor the States' consideration of the alcohol, drug abuse, and mental health services made available to jail inmates.

GAO RECOMMENDATION

We recommend that the Secretary of HHS and the Attorney General require the Administrators of LEAA and ADAMHA and the Director, NIC, jointly:

> "--Establish a mechanism for continuing coordination among LEAA, NIC, and the HHS institutes to better assure their efforts regarding mental health care for jail inmates are directed towards common goals and are mutually supportive."

DEPARTMENT COMMENT

We concur in principle. The Administrator, Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), has been directed to review the mechanisms already existing among the Law Enforcement Assistance Administration (LEAA), the National Institute of Corrections (NIC), and the Department of Health and Human Services (HHS) to assure maximum collaboration, as well as the adequacy of legislative authorizations, and to maximize ongoing, documentable coordination in providing appropriate, quality mental health care to jail inmates. In those respects in which existing mechanisms are found to be inadequate, they will be modified in collaboration with the Attorney General and other authorities. We believe that modification of existing mechanisms rather than the establishment of a new mechanism will accomplish the intent, with which we concur, of the recommendation.

"--Define and agree upon the agencies' and institutes' respective responsibilities and roles in meeting inmates' needs and, as a corollary, develop a joint strategy for their assistance efforts."

We partially concur. The actions described in the foregoing Department comment will insure that responsibilities, roles and a joint strategy are more clearly defined and understood among the interested parties. This review, and HHS participation in the general clarification and strengthening of responsibilities and roles, is expected to be accomplished by the end of Fiscal Year 1981.

GAO RECOMMENDATION

We also recommend that the Secretary, HHS:

Require the Administrator, ADAMHA to:

"--Direct NIMH and NIAAA to revise guidelines for comprehensive statewide mental health and alcoholism plans to make it clear that State agencies should assess the needs of jail inmates in the planning process."

DEPARTMENT COMMENT

We concur. The National Institue of Mental Health (NIMH) will revise guidelines for statewide mental health plans to emphasize consideration of the needs of jail inmates in the development of the plans. This revision should be accomplished by the end of Fiscal Year 1981.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) published Guidelines for Annual Program Activities and Performance Reports for State Alcoholism Plans on March 14, 1980. These revised Guidelines required State Alcoholism Authorities to "establish goals and objectives for programs in conjunction with the criminal justice system." Further, the Guidelines required States to report on "the degree of coordination and collaboration with the criminal justice system of alcoholism programs resulting from that liaison." In formal and informal dealings with the State Alcohol Authorities, NIAAA continues to emphasize the importance of forming effective liaisons between treatment networks and the criminal justice system, and encourages and provides technical assistance to them in support of their efforts to make needed services available to jail inmates.

"--Direct NIMH to furnish guidelines to community mental health centers and State agencies responsible for mental health that specifically describe the ways in which centers could assist jails."

DEPARTMENT COMMENT

We concur. NIMH will prepare guidelines that specifically describe ways in which assistance can be provided to jail inmates. We would expect to be able to distribute the guidelines early in Fiscal Year 1982.

> "--Direct NIAAA to evaluate its program to assist States that adopt provisions of the Uniform Alcoholism and Intoxication Treatment Act and ensure that program results are made known to other States."

DEPARTMENT COMMENT

We concur. The NIAAA operating plan developed for Fiscal Year 1981 includes a contract to evaluate the present status of Uniform Act activities in the States, and to make this updated information available to all the States.

In 1976, NIAAA assessed State activities of the first 16 Uniform Act Grants awarded. The report of this assessment was distributed to all State Alcoholism Authorities. NIAAA continues to give high priority to assessing the effectiveness of the Uniform Act over time, and to keeping other States informed of progress and problems encountered by those States implementing the Act.

> "--Strengthen NIDA procedures for reviewing State drug agencies' comprehensive plans to ensure that the drug treatment needs of jail inmates are considered."

DEPARTMENT COMMENT

We concur in principle. The National Institute on Drug Abuse (NIDA), where appropriate, will encourage the State agencies to include this area of under-served individuals in the State plans for formula grants. However, legislation authorizing the programs does not provide for earmarking of funds for specific purposes or groups. The States may exercise their discretionary rights over formula monies and award funds to other priorities. We therefore, cannot compel a State to consider in its planning the needs of jail inmates or to earmark formula funds specifically for their treatment. We can, however, encourage the State health agencies to address the drug treatment needs of jail inmates.

> "--Direct NIDA to remove its present limitation on the percentage of community drug treatment slots supported by Drug Abuse Office and Treatment Act funds that can be allocated for persons referred from the criminal justice system, to permit States and localities to allocate them as they deem warranted based on their determinations of local needs and priorities."

DEPARTMENT COMMENT

We do not concur. NIDA has no limitation on the percentage of drug treatment slots that can be allocated for persons referred from the criminal justice system. NIDA does require its community-based treatment grantees, and their contractors, to give priority to clients referred from the criminal justice system. Such preference must be given at least to a level of ten percent of the grantee's slot capacity. Thus, while there is a minimum requirement, there is no maximum limitation.

TECHNICAL COMMENTS

On pages 41 and 42 of the draft report, a somewhat related issue is reiterated from the earlier GAO report on prisons. This issue concerns the basis for, and the maintenance of, NIDA's policy on the treatment of incarcerated individuals. The discussion of this issue indicates that there still remains a misunderstanding.

NIDA's policy on the treatment of incarcerated individuals is not, as is indicated on pages 41 and 42, based upon the (LEAA) Treatment Alternatives to Street Crime (TASC) program. Current policy has been primarily based on NIDA's legislative mandate (including the legislative history of the various applicable Acts) to fund community-based drug treatment programs to treat individuals who reside in the general community. This mission dates back to 1966 with the passage of P.L. 89-793 (The Narcotic Addict Rehabilitation Act of 1966). While NIDA's community-based role is also reiterated in the various Federal Strategies, it predates any of them. This community-based role is also reiterated in subsequent legislation and legislative history (e.g., P.L. 96-181, "The Drug Abuse Prevention, Treatment, and Rehabilitation Amendments of 1979").

A position statement, relative to current Federal strategy, was issued on March 19, 1980, in a memorandum from the Honorable Lee. I. Dogoloff to members of the Treatment Rehabilitation Steering Group (which is primarily comprised of representatives from the Federal agencies involved in the national drug abuse effort, including NIDA and LEAA). This memorandum, entitled "FEDERAL POLICY ON THE TREATMENT OF INCARCERATED OFFENDERS," states the current revised Federal policy on the treatment of incarcerated offenders who are drug abusers. It clearly establishes that the primary responsibility for the treatment within State and local correction systems of incarcerated offenders who have histories of drug abuse rests with State and local governments. The Federal role is limited to "developing voluntary standards and guidelines, knowledge development in the areas of treatment modalities and linkage systems (pretrial, post trial, post incarceration, employment and training), and a modest demonstration effort." The policy also clearly reiterates HEW's (now HHS's) community-based role and its treatment of incarcerated offenders (through the use of NIDA-funded treatment slots) policy.

A review of LEAA's legislation and legislative history will reveal that this agency received a legislative mandate in 1976 requiring that, as part of its mandatory State Plan requirements (P.L. 94-503, Sections 109 and 110), it consider and provide for the needs of convicted offenders with alcohol or drug abuse problems who are incarcerated or on supervised work release. While this agency's mandate has shifted over the years, it needs to be examined and understood in order to provide a complete perspective on this issue.

While LEAA's legislative mandate has shifted somewhat over the years, NIDA's has remained consistent. The above clarification focuses on the misunderstanding and miscommunication which was evident in the draft report's discussion of NIDA's initial and continuing legislative mandate(s). The issues of need for services to this population (which is recognized), resources, etc., are not addressed. These issues need to be continually examined and addressed by both the legislative and executive branches of Federal, State and local governments.

LIST OF ORGANIZATIONS VISITED OR CONTACTED

STATE	STATE, MUNICIPAL, OR PRIVATE ORGANIZATIONS
Illinois	Dangerous Drugs Commission
	Department of Corrections
	Department of Mental Health and Developmental Disabilities
	Illinois Law Enforcement Commission
	Illinois Prison and Jail Projects, Chicago
	Illinois State Medical Society
	Illinois State Sheriffs Association
	Illinois United Methodist Church, Ministry of Criminal Justice, Chicago
Michigan	Department of Corrections
	Department of Management and Budget
	Department of Mental Health
	Department of Public Health
	Grand Traverse County Jail
	Ingham County Jail
	Michigan State Medical Society
	Michigan Sheriffs Association
	Northwestern Michigan Half-Way Houses, Traverse City
	Offender Aid and Restoration, Pontiac
	Treatment Alternatives to Street Crime, Saginaw and Detroit
	Third Level Crisis Intervention Center, Inc., Traverse City
New York	Commission of Corrections
	Division of Alcoholism and Alcohol Abuse
	Division of Criminal Justice Services
	Division of Substance Abuse Services
	Office of Mental Health
	Office of Mental Retardation and Developmental Disabilities
	New York City Board of Corrections
	New York State Sheriffs Association
North Carolina	Offender Aid and Restoration, Fayetteville
	Department of Crime Control and Public Safety
	Department of Human Resources
	Albemarle District Jail

	Buncombe County Jail
	Cumberland County Jail
	Pitt County Jail
	Albemarle Mental Health Center, Elizabeth City
	Blue Ridge Community Mental Health Center, Ashville
	Cumberland County Mental Health Center, Fayetteville
	Pitt County Mental Health Center, Greenville
	North Carolina Medical Society
	North Carolina Sheriff's Association
	Treatment Alternatives to Street Crime, Charlotte
Ohio	Department of Economic and Community Development
	Department of Mental Health and Mental Retardation
	Department of Health
	Department of Rehabilitation and Correction
	Cuyahoga County Corrections Center
	Lucas County Corrections Center
	Sandusky County Jail
	Cuyahoga County Community Mental Health and Retardation Board
	Lucas County Mental Health and Mental Retardation Board
	Buckeye State Sheriffs' Association
	Elizabeth A. Zepf Community Mental Health Center, Toledo
	Ohio State Medical Association
	Psychiatric Clinic of the Municipal Court of Common Pleas, Cleveland
South Carolina	Commission on Alcohol and Drug Abuse
	Department of Corrections
	Department of Mental Health
	Office of Criminal Justice Programs
	South Carolina Sheriff's Association
Virginia	Department of Mental Health and Mental Retardation
	Department of Corrections
	Division of Justice and Crime Prevention
	Accomack County Jail
	Chesapeake City Jail
	Greensville County Jail

	Eastern Shore Mental Health Center, Nassawadox
	Treatment Alternatives to Street Crime, Richmond Virginia State Sheriff's Association
	Department of Health Department of Welfare Greensville-Emporia Mental Health Clinic, Emporia Mental Health and Mental Retardation Services Board of Chesapeake Offender Aid and Restoration, Charlottesville and Richmond
West Virginia	Criminal Justice and Highway Safety Division Shawnee Hills Community Mental Health Retardation Center, Charleston Legal Services of Charleston, West Virginia West Virginia Sheriff's Association
Wisconsin	Department of Health and Social Services Wisconsin Council on Criminal Justice Badgers Sheriff Association, Madison Office of the State Public Defender, Madison State Medical Society of Wisconsin Treatment Alternatives to Street Crime, Milwaukee University of Wisconsin Extension Center for Community Leadership Development, Madison

LOCATION	NATIONAL ASSOCIATIONS
Arlington, Va.	Mental Health Association
Chicago, Ill.	American Medical Association John Howard Association
Rockville, Md.	American Correctional Association
Washington, D.C. Chicago, Ill. Columbia, S. Car. Columbus, Ohio Greensboro, N. Car. Richmond. Va.	American Civil Liberties Union

Washington, D.C.	American Psychiatric Association American Psychological Association National Association of Counties National Coalition for Jail Reform National Sheriffs' Association

LOCATION	FEDERAL ORGANIZATIONS
Washington, D.C.	Bureau of Prisons, DOJ
Washington, D.C.	Law Enforcement Assistance Administration, DOJ
Rockville, Md.	National Institute on Alcohol Abuse and Alcoholism, HHS
Rockville, Md.	National Institute on Drug Abuse, HHS
Rockville, Md.	National Institute of Mental Health, HHS
Washington, D.C.	National Institute of Corrections
Boulder, Colo.	National Institute of Corrections Jail Center, DOJ
McClean, Va.	U.S. Marshals Service, DOJ
Charleston, W.Va.	U.S. Marshal, DOJ
Chicago, Ill.	U.S. Marshal, DOJ
Cleveland, Ohio	U.S. Marshal, DOJ
Columbia, S. Car.	U.S. Marshal, DOJ

LOCATION	FEDERAL ORGANIZATIONS
Madison, Wisc.	U.S. Marshal, DOJ
Norfolk, Va.	U.S. Marshal, DOJ
Raleigh, N. Car.	U.S. Marshal, DOJ
	NIC AREA RESOURCE CENTERS
Rockville, Md.	Montgomery County Department of Correction and Rehabilitation
New Orleans, La.	Orleans Parish Corrections Center

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